# QUEENSLAND CIVIL AND ADMINISTRATIVE TRIBUNAL

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| CITATION: | *Health Ombudsman v Shi* [2022] QCAT 98 |
| PARTIES: | **DIRECTOR OF PROCEEDINGS ON BEHALF OF THE HEALTH OMBUDSMAN**<br>(applicant)<br><br>**v**<br><br>**KAI YING SHI**<br>(respondent) |
| APPLICATION NO/S: | OCR 273/20 |
| MATTER TYPE: | Occupational regulation matters |
| DELIVERED ON: | 3 March 2022 *(ex tempore)* |
| HEARING DATE: | 3 March 2022 |
| HEARD AT: | On the papers |
| DECISION OF: | Judge Dann, Deputy President<br>Assisted by:<br>Ms Laura Dyer<br>Mr Graeme Kerridge<br>Ms Barbara Low Soong |

ORDERS:

1. **Pursuant to s 107(2)(b)(iii) of the *Health Ombudsman Act 2013* (HO Act) the respondent has behaved in a way that constitutes professional misconduct.**
2. **Pursuant to s 107(3)(a) of the HO Act the respondent is reprimanded.**
3. **Pursuant to section 107(3)(b)(iii) of the HO Act the respondent must not practice as a registered nurse in an authorised Mental Health Service.**
4. **Pursuant to section 107(3)(b)(iii) of the HO Act, the respondent may practice only in places of practice approved by the Nursing and Midwifery Board for a period of three years from the date of this order. For the purpose of this order, practice is defined as any role, whether remunerated or not, in which the individual uses their skills and knowledge as a registered nurse in their profession. It is not restricted to the provision of direct clinical care and includes using the knowledge and skills of the nursing profession in a direct nonclinical relationship with a client, working in management,**

**administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe effective delivery of services in the nursing industry.**

**5. Each party bears its own costs of the proceedings.**

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| CATCHWORDS: | PROFESSIONS AND TRADES – HEALTH CARE PROFESSIONALS – NURSES – DISCIPLINARY PROCEEDINGS – PROFESSIONAL MISCONDUCT – where the respondent was a registered nurse – where the respondent admits engaging in a close but not sexual relationship with Patient A – where Patient A suffered complex and severe mental illness – where the respondent was part of Patient A's treatment team for 10 months prior to commencing the relationship – where there is medical evidence of a causal link between the respondent's psychiatric condition he was suffering at the time and the inappropriate relationship – whether the respondents registration should be suspended – whether the respondent should have conditions imposed upon his registration |
| | Health Practitioner Regulation National Law (Queensland) s 5 |
| | *Health Ombudsman Act 2013* (Qld) s 107 |
| | *Craig v Medical Board of South Australia* (2001) 79 SASR 545 |
| | *Health Ombudsman* v *Bothwell* [2020] QCAT 393 |
| | *Health Ombudsman v Jolley* [2019] QCAT 173 |
| | *Health Ombudsman* v *Kimpton* [2018] QCAT 405 |
| | *Health Ombudsman v Wood* [2019[ QCAT 35 |
| | *Legal Services Commissioner v McLeod* [2020] QCAT 371 |
| | *Nursing and Midwifery Board of Australia v Tainton* [2014] QCAT 161 |
| APPEARANCES & REPRESENTATION: | |
| Applicant: | C.J. Lloyd, instructed by the Office of the Health Ombudsman |
| Respondent: | B.M. Solomon, instructed by Gilchrist Connell |

**REASONS FOR DECISION**

[1] These disciplinary proceedings were referred to the Tribunal by the applicant Director on 31 August 2020. There is a statement of agreed facts dated 11 May 2021 and signed by the legal representatives of the applicant and the respondent.

[2] The respondent was, at all times material to the allegations the subject of the referral, a registered nurse.

[3] The respondent, by his response to the referral, admitted the matters the subject of the allegations contained in the referral. He raised certain matters as to his own mental health as a part of his response.

[4] The respondent is presently 51 years old. He was first registered as an enrolled nurse in 1998. In 2007 he obtained registration as a registered nurse. He currently holds Division 1 general registration with the Nursing and Midwifery Board of Australia pursuant to the Health Practitioner Regulation National Law (Queensland) (**National Law**).

**The conduct the subject of the referral**

[5] The conduct giving rise to the referral occurred in 2018 and 2019.

[6] Between 12 February and 17 December 2018 the respondent was employed by Metro Health Addiction and Mental Health Services as a registered nurse on a temporary contract at one of its community care units. I will call it the CCU. The CCU is a treatment facility that provides 24 hour clinical care and supervised rehabilitation to adults with mental health issues who are in recovery and require additional support to transition successfully to independent community living.

[7] From 19 December 2018 – September 2019 the respondent was employed as a registered nurse at the Bayside Mental Health Service Yugaipa Inpatient Unit (Yugaipa). He resigned from that position in September 2019.

[8] Both allegations the subject of the referral relate to a single patient, Patient A.

[9] Patient A was a 31 year old patient at the CCU between 10 August 2017 and 3 April 2019. Patient A suffered from complex and severe mental illness, with several co morbid diagnoses. The parties agree Patient A was extremely vulnerable throughout the time spent in CCU and that she required comprehensive psychiatric management from the multidisciplinary team at CCU. The CCU offers its services in a residential setting that allows residents to stay in self-contained units on site while they receive treatment. At all material times Patient A was a resident of the CCU.

[10] The respondent was a part of Patient A's treatment team for the duration of his employment at the CCU.

[11] The conduct the subject of the first allegation involves the following:

(a) at some point prior to 4 December 2018 the respondent and Patient A exchanged phone numbers;

(b) on 4 December 2018 the respondent sent Patient A 10 SMS/text messages and left her a voice message;

(c) on 5 December 2018 the respondent sent Patient A 22 SMS/text messages and spoke to her on the telephone on two occasions, each for more than 1 hour;

(d) on 6 December 2018:

(i) after the respondent gave Patient A her medication, she hugged and kissed him;

(ii) he received a text message from Patient A to the effect "I miss you already";

(iii) the respondent spoke with her on the telephone for nearly 1 hour and 20 minutes;

(e) on 7 December 2018 the respondent met Patient A for coffee at a shopping centre and thereafter they went for a drive in his car to the Gold Coast and went to the beach, where they hugged. They also spoke on the phone 5 times, on one occasion for 1 hour and 20 minutes;

(f) on and from 8 December 2018 the respondent drove Patient A to doctors' appointments, went with her grocery shopping and picked her up after his work shifts;

(g) between 4 December 2018 and 27 January 2019 the respondent contacted Patient A on more than 500 occasions, either by text message or voice call (that includes the text messages I've already referred to). Examples of the messages were that he said to her "Good morning honey" or "miss you honey xo" or "how is your foot honey" and she said to him things such as "love you honey xo" and "miss you honey"; and

(h) between 31 December 2018 and 27 January 2019 the respondent engaged in a personal relationship with Patient A during which they engaged in hugging and kissing, he saw Patient A naked and Patient A introduced him to her mother who approved. The relationship ceased when the respondent received a show cause letter from his employer.

[12] The parties agree that the respondent was aware that Patient A was highly vulnerable given his direct provision of care to her and because he formed part of the multi-disciplinary rehabilitation team which was treating her.

[13] Patient A made the disclosure of the relationship to her senior social worker on 24 January 2019, when they met and were discussing accommodation arrangements prior to her discharge from the CCU.

[14] That day, she was observed to exhibit signs of distress about the relationship being exposed to hospital staff. The next day on review by her psychiatrist, Patient A was very tearful and extremely distressed about the prospects of losing the relationship, feeling responsible that the relationship had been exposed and feeling concerned that the respondent may experience adverse consequences.

[15] Her psychiatrist's opinion consequent upon that review included that her already fragile mental state was significantly disturbed by the relationship, her anger with the staff who had discovered the relationship had caused a rupture in what had previously been a very good therapeutic relationship and Patient A no longer perceived the CCU staff to be acting in her best interests.

[16] The second allegation involved the respondent accessing Patient A's clinical file and clinical notes without authorisation on 12 occasions in December 2018 and January 2019 (after he had completed his contract at the CCU). At these times he did not have patient care of Patient A. Having accessed records on the occasions other than on the first occasion in December 2018, to find out details of Patient A's housing and transitional arrangements, he relayed information on those matters to Patient A.

**The respondent's admissions and submissions**

[17] It is part of the agreed facts between the appellant and the respondent that:

(a) the respondent's written response to the show cause letter included admissions and submissions to the following effect:

(i) that his exchanging of personal telephone numbers with Patient A and then continuing to maintain contact with her and allowing a personal relationship to develop was inappropriate and inconsistent with the professional expectations for a registered nurse;

(ii) at the time he did not believe that giving Patient A his personal number was a breach of professional boundaries;

(iii) he mistakenly believed he was permitted to have contact with Patient A as a former patient, despite having been involved in her treatment;

(iv) he acknowledged that a boundary violation had occurred, it was inadvertent and thoughtless and a misuse of his power in the nurse-patient relationship;

(v) he was deeply regretful and remorseful that his lapse of judgment had the potential to cause Patient A detriment and put his significant career as a nursing professional at risk;

(vi) he accepted that a breach of professional boundaries led to a violation of his professional responsibility and acknowledged that he must abstain from such behaviour;

(b) then, in a recorded interview with Metro South Health and Hospital Service on 4 April 2019 the respondent:

(i) made admissions that he and Patient A drove to the Gold Coast in his car and they went to the beach and hugged; that he had seen patient A naked and that he and Patient A were in a boyfriend and girlfriend relationship and he had met Patient A's mother, who approved of this, that Patient A called him "honey";

(ii) said he did not deliberately engage in a relationship with Patient A due to his lack of knowledge of boundary violation;

(iii) agreed that the records showing the instances he had accessed Patient A's records were a true reflection of the times he had done so and that he had accessed Patient A's records to find out more information about Patient A's discharge accommodation which Patient A had asked him to do. He admitted that accessing Patient A's records was the wrong thing to do and he provided no reasonable explanation for doing so without a legitimate purpose;

(c) in responses during the OHO investigation into the matter the respondent made the following further admissions and submissions:

(i) as he had misplaced his phone, on 23 December 2018 he used his login in to access Patient A's clinical records and get her phone number as he was concerned she may have been trying to get in contact with him;

(ii) Patient A had asked him to find out more information about her planned discharged housing arrangements which was why he logged in on 22 January 2019 and read the records, the information from which he then passed onto Patient A;

(iii) he had suffered personal turmoil since 2017 consequent upon a marriage breakdown, loss of custody of his three children and being homeless for several weeks;

(iv) Patient A had suggested to him that he could offer her support similar to the social support she used to receive from a non-government organisation where staff would take her out to coffee, shopping and medical appointments;

(v) that on 6 December 2018 Patient A gave him a hug and a kiss after he gave her medication and later he got a text message from her saying "I miss you already":

(vi) after the end of his employment at the CCU, he and Patient A began meeting more often;

(vii) in about January 2019 he and Patient A commenced a romantic relationship after Patient A had introduced him to her mother who approved of the relationship;

(viii) the relationship ended when he got a show cause letter from his employer at which point he realised he had made a mistake and was in breach of professional ethics;

(ix) he had not previously had training on professional boundary violations and he did not know that what he did was wrong;

(x) he had subsequently completed a course on safe professional boundaries which gave him an understanding of industry ethical standards; and

(xi) he is extremely remorseful and regrets his lapse of judgment caused detriment to Patient A.

[18] The parties agree that:

(a) in respect of Allegation One, the respondent breached:

(i) principle 4, Professional Boundaries, in the Code of Conduct for Nurses and particularly that to maintain professional boundaries nurses must:

A. recognise the inherent power imbalance between nurses and people in their care and establish and maintain professional boundaries; and

B. actively manage the person's expectations and be clear about professional boundaries that must exist in professional relationships for objectivity in care and must prepare the person for when the episode of care ends;

(ii) principles 1 and 2 of the International Council of Nurses Code of ethics for midwives, which require nurses to maintain a standard of personal health so that their ability to provide care is not compromised and to

maintain standards of personal conduct which reflect well on the profession and enhance its image and public confidence;

(b) In respect of Allegation 2 that the respondent:

(i) was in breach of Principle 3 of the Code of Conduct already referred to which require nurses to access records only when professionally involved in the care of the person and authorised to do so; and

(ii) was also in breach of elements 1 and 2 of the Code of Ethics already referred to which require nurses to hold in confidence personal information and to use judgment in sharing this information and to maintain standards of professional conduct which reflect well on the procession and enhance its image and public confidence.

**The respondent's professional and disciplinary history**

[19] The respondent was born and raised in China until he came to Australia in 1992 as a 21 year old to study.

[20] The respondent obtained the qualifications of enrolled nurse in 1998 after obtaining a Certificate IV in Nursing from the Royal Ryde Rehabilitation Centre. He obtained his Bachelor of Nursing from the Australian Catholic University in 2006.

[21] In 2017 the respondent obtained a Bachelor of Medicine and a Bachelor of Surgery from the Oceania University of Medicine in Western Samoa. He has not ever been registered to practice medicine in Australia.

[22] The respondent was 48 years old at the time of the events the subject of the referral.

[23] Prior to the conduct the subject of the present referral, the respondent had not previously been the subject of disciplinary proceedings.

[24] The respondent attended Dr Nigel Prior, Consultant Psychiatrist, for preparation of a medico legal report. That report, dated 3 June 2021, was contained in the hearing brief and both parties have referred to aspects of it in their submissions.

[25] Relevantly, Dr Prior recorded:

(a) the respondent acknowledged that Patient A was vulnerable in the month of December 2018 and that she was depressed and experiencing suicidal ideation[1];

(b) the respondent stated:

(i) the respondent had experienced severe abuse in his childhood from his father/ mother and alleged sexual abuse from one of his stepmothers. He had been bullied at school and been previously diagnosed with depression in 1996;[2]

(ii) the respondent had wanted to help Patient A and become more involved in her care because of his own circumstances of early childhood trauma

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1 Dr Prior's report at [4.2].

2 Dr Prior's report at [15.12].

and deprivation and his own homelessness after his marriage break down.[3] In retrospect he believed that he had made a mistake;[4]

(iii) he was not aware of the rules and regulations surrounding the appropriateness of having a relationship with a present or past patient, had not been trained as a psychiatric nurse and therefore, did not understand the boundaries;[5]

(iv) he believed that if he was no longer working in the unit then he could continue his relationship with Patient A;[6]

(v) he thought Patient A was looking for an intimate relationship and that he had been taken advantage of emotionally by the patient. He had found it hard to say 'no' and to set boundaries;[7]

(vi) the respondent advised Dr Prior that after he completed a professional boundaries course in September 2019 he had become more aware of the rules, policies and procedures surrounding appropriate treatment of patients, patients' rights and the care and protection that they required;[8]

(vii) he felt remorse for his conduct and was regretful of his lapse of judgment causing detriment to Patient A;[9]

(viii) in the aftermath, he sought and received treatment by a psychiatrist and psychologist for his condition;[10]

(ix) He had no plans to nurse in psychiatry and was looking to work in the aged care area.[11]

[26] Dr Prior drew certain conclusions from the information before him. Those conclusions included that:

(a) at the relevant time the respondent was experiencing the aftermath of a marital breakdown and had been suffering a likely Major Depressive Disorder from 2016 onwards[12];

(b) the presence of the Major Depression likely impaired the respondent's judgment and the social isolation and marital breakdown also made him more vulnerable and open to the affectionate attentions of Patient A;[13]

(c) the respondent was aware that Patient A and her mother would not reveal the relationship to the other clinical team members and he had accessed the patient's records to investigate what information relating to his conduct had been reported to hospital staff. Because of this, Dr Prior reported that the respondent had demonstrated *'some awareness that what he was doing at the*

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3 Dr Prior's report at [4.2].
4 Dr Prior's report at [4.7].
5 Dr Prior's report at [4.7].
6 Dr Prior's report at [4.7j.
7 Dr Prior's report at [4,8].
8 Dr Prior's report at [15.10].
9 Dr Prior's report at [15.10].
10 Dr Prior's report at [4.12].
11 Dr Prior's report at [4.10].
12 Dr Prior's report at [16.1.1].
13 Dr Prior's report at [16.12].

*time was wrong, some degree of evasion and attempts to avoid detection and to investigate negative implications for himself;'*[14]

(d) the respondent continued to show limited genuine insight into his behaviour, the origins of his behaviour and the negative impact of his behaviour upon Patient A's mental state, the treatment she was receiving and the potential adverse impact that this has had on the therapeutic relationship with her treating team;[15]

(e) the respondent demonstrated an intellectual understanding of ongoing professional boundaries working in the health industry. He is now more aware of the inappropriateness of crossing boundaries and engaging in personal and intimate relationships with patients and accessing patient's records for personal reasons. He will be more likely in future to adhere to the rules, regulations and policies in order to avoid further consequences to himself;

(f) despite the respondent's limited insight he represented a low-risk of re-engaging in the behaviour that led to the offence. This was because of the respondent's greater understanding of the inappropriateness of these behaviours and Dr Prior concluded, therefore reduced the likelihood of them re-occurring;

(g) the respondent remained a vulnerable person and that if his mental state deteriorated there was *'a possibility that he may step outside of his professional role in order to seek comfort, solace and nurturing from patients, particularly female patients*'[16];

(h) based on his then current psychological capacity the respondent was fit to work as a registered nurse, but unfit to work in the mental health area having regard to his significant vulnerabilities in terms of his personality development, psychiatric vulnerabilities and intellectual rather than genuine insight into the complex issue of boundary violations. Dr Prior considered that the mental health environment would place the respondent at increased risk of crossing professional boundaries with patients, although he considered this was a low risk;[17]

(i) it would be more appropriate that the respondent works in an area such as aged care, where he was presently working, where the risk of boundary violations were less likely to occur. He further posited that should he work in these areas that it would be in a pre-approved position by AHPRA and that he should be subject to supervised practice with regular supervisory reports to be submitted.[18]

**The parties' submissions**

[27] The applicant has filed written submissions dated 15 September 2021. In them, in summary, the applicant submits:

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14 Dr Prior's report at [16.1.4].
15 Dr Prior's report at [16.2.2].
16 Dr Prior's report at [16.4.2].
17 Dr Prior's report at [16.5.2].
18 Dr Prior's report at [16.5.3].

(a) the respondent's conduct constitutes professional misconduct within the meaning of that term in the National Law;

(b) the purpose of disciplinary proceedings is to maintain professional standards and public confidence in the profession and to protect the public. The sanction in a particular case must be considered based on the peculiar facts and to craft something which best achieves those purposes;

(c) the protection of the public has various aspects. One articulation of this is in the following statement from the Full Court of the Supreme Court of South Australia:

"*The public may be protected by preventing a person from practising a profession, by limiting the right of practise or by making it clear that certain conduct is not acceptable*"[19];

(d) the Tribunal needs to consider the maintenance of professional standards, issues of general and personal deterrence, an assessment of any ongoing risk presented by the practitioner, insight demonstrated by the practitioner and evidence of rehabilitation[20];

(e) in this case the applicant submits:

(i) the conduct is inherently serious. It involved multiple breaches of the Code of Conduct. The respondent had been in Patient A's treating team for 10 months. He was aware that the patient was highly vulnerable and, despite this, he entered into a close relationship with her. There was a necessary power imbalance between them and it was essential that the relationship remained professional. The relationship only ended after Patient A disclosed its existence. Patient A was emotionally attached to the respondent and the inappropriate relationship had a negative impact on her well-being, as evidenced by the opinion of her treating psychiatrist, (which is part of the agreed facts);

(ii) the respondent did not work as a registered nurse for 17 months from September 2019 to March 2021;

(iii) based on Dr Prior's report, the respondent had a fundamental lack of awareness about the inappropriateness of his behaviour. This was based on what the respondent told Dr Prior about his lack of awareness of the requirement to maintain professional boundaries with patients, as he had not been trained as a psychiatric nurse. Pointing to his experience as an enrolled nurse for 20 years at the time the conduct occurred and as a registered nurse for over 10 years at the time the conduct occurred, the applicant submitted this explanation was difficult to accept, as all nurses, regardless of the treatment setting, are required to maintain personal boundaries;

(iv) this lack of awareness of what is inappropriate conduct is compounded by the limited genuine insight into his conduct and his attempt to minimise his own conduct; and

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19 *Craig v Medical Board of South Australia* (2001) 79 SASR 545 at [48].

20 Applicant's outline of submissions at [46] – [47].

(v) as to the respondent's fitness for practice, relevant considerations for the Tribunal are that based on the information in Dr Prior's report, cancellation of the respondent's registration is not warranted. An appropriate protective order would be to suspend registration for a period of 12 months from the date of the order to recognise the seriousness of the conduct, followed on by additional conditions on registration to address the residual risk.

[28] The applicant noted that there was authority for the proposition that general deterrence may be sensibly moderated where there is a mental disorder which has contributed to a lawyer's misconduct[21] and submitted that each of general and specific deterrence could be sensibly moderated in light of Dr Prior's opinion that the respondent was suffering from a Major Depressive Disorder at the time and it likely impaired his judgment in entering into the relationship.

[29] The applicant contends that an order for suspension is necessary to maintain professional standards and to indicate that the vulnerable patient's health and well-being will be protected from like-minded practitioners. Further, the applicant submits for conditions prohibiting the respondent from working in an authorised mental health service and that any position requiring the Board's approval would properly mitigate the risks identified by Dr Prior. In written submissions the applicant contended for an order without temporal limitation, however orally the applicant accepted a period of 6 – 12 months would be appropriate.

[30] The respondent has provided the Tribunal with written submissions dated 5 October 2021. The considerations the respondent urges upon the Tribunal are:

(a) the respondent had been in a period of psychological turmoil since 2017 up to the time of his relationship with Patient A;

(b) the respondent's relationship with Patient A ended when he received the show cause letter in late January 2019. He realised then he had made a terrible mistake and was in breach of his professional ethics. He immediately ended contact and had not had contact with Patient A since that time;

(c) subsequent to the matters the subject of the referral, of his own volition, he completed a course on safe professional boundaries which gave him an understanding on the health industry's ethical standards. As part of that course, he was required to complete a number of short answer questions and a reflective essay to demonstrate that he had achieved competency and receive the certificate. The respondent completed the course on 11 September 2019;

(d) the respondent is extremely remorseful and regrets his actions. He accepts that his lapse in judgment caused detriment to Patient A. He believed that his professional relationship with Patient A had ended when he ceased employment with the CCU in December 2018, and did not appreciate at that time it would be regarded as unethical to commence a relationship with someone who was a former patient. Specifically, the respondent points to the aspect of his interview with the OHO where he acknowledged that he made

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21 *Legal Services Commissioner v McLeod* [2020] QCAT 371

serious mistakes and is *"not trying to wash his guilt off, but he did not intentionally try to get into a relationship with Patient A"*[22];

(e) since gaining insight into his wrongdoing, he voluntarily withdrew from employment in the health industry for a period of 17 months to reflect upon his actions and to receive treatment. This hiatus was self-imposed by the respondent to allow him time to gain perspective on his professional misconduct, to obtain some additional professional development training and to restore his mental health;

(f) in terms of employment since that time:

(i) he worked from March – June 2021 in a part time role for 10 hours a week to assist an elderly Chinese man with personal care and some household duties;

(ii) from mid May 2021, through an employment agency, the respondent was placed to work casually at various nursing homes. His main duties included medication administration, liaising with allied health, doctors and relatives for resident care, wound treatment and supervision of carers;

(iii) from in or about July 2021 to January 2022, the respondent worked as a registered nurse at Jeta Gardens in Bethania, Logan;

(iv) since that time, the respondent has worked for Blue Care in a retirement village at Carbrook as a registered nurse;

(v) the respondent also currently works to develop nursing policies for management, incident reporting and procedures and educate carers to administer medication in the community for Chinese Fraternity Association of Queensland on an ad-hoc casual basis;

(g) in oral submissions representatives for Mr Shi informed the Tribunal he had recently remarried and he had weekly access to his children; and

(h) Aspects of Dr Prior's report which highlighted matters in relation to his background as a child, his desire to help Patient A, the completion of the course following September 2019, his remorse and regret, his receipt of treatment, his lack of plans to nurse in psychiatry, the causal nexus between his marital breakdown and his depressive disorder and his impairment of judgment and that he was fit to work as a registered nurse.

**Discussion and Sanction**

[31] Whilst the parties have agreed that the admitted conduct constitutes professional misconduct[23], it is necessary for the Tribunal to determine, pursuant to s 107 of the Act:

(a) whether the respondent's conduct constitutes 'unsatisfactory professional performance", 'unprofessional conduct' or 'professional misconduct'; and

(b) the appropriate disciplinary sanction.

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22 Transcript of interview between respondent and Metro South Health, dated 4 April 2019.

23 Applicant's outline of submissions at [18]; respondent's outline of submissions at [14].

[32] The Tribunal is satisfied that the respondent's conduct contained in the agreed facts constitutes professional misconduct as defined by section 5 of the National Law.

[33] When turning to sanction, it is important that these proceedings are protective in nature and not punitive. The Tribunal must regard the health and safety of the public as paramount[24].

[34] Issues relevant to sanction include the seriousness of the conduct, whether the practitioner presents any ongoing risk to the public of similar misconduct and the degree of insight which the respondent has shown. Other factors, which may be aggravating or mitigating, may be relevant in a particular case.

[35] As has been observed in many cases, whilst recourse to earlier decisions can assist in ensuring that there is consistency of outcome in similar cases, rarely, if ever, are cases truly comparable and the Tribunal is required to consider the individual and unique circumstances of every case.

[36] The applicant referred the Tribunal to *Health Ombudsman v Wood*[25], *Health Ombudsman v Jolley* [26] and *Nursing and Midwifery Board of Australia v Tainton*[27], submitting there were aspects of similarity in each of *Wood* and *Jolley*.

[37] In *Health Ombudsman v Wood*[28], a former enrolled nurse with more than 30-years-experience, developed a personal relationship with a female patient, who had a history of depressive illness and alcoholism, who had been admitted to a Cairns Clinic. During her admission to the clinic the practitioner provided therapeutic care to the patient. The relationship's physical intimacy was confined to hugging and kissing. After discharge, the relationship progressed to the point the parties had decided to marry. The patient was later re-admitted and the fact of the relationship was ascertained on that readmission. In an investigation the respondent admitted the breach of professional boundaries, but stated the relationship was mutual. In that case, the Tribunal did not accept the parties' position that the respondent was not aware of his obligation to maintain professional boundaries, finding the respondent was aware of his obligation in that regard. The Tribunal determined that the practitioner had failed to show full insight into the seriousness of the boundary violation (because he did not accept there was a power imbalance between himself and the patient) and the potential for the patient suffering harm as a consequence. (The evidence was that there were in fact no adverse consequences to the patient as contended for by the regulator). The Tribunal found the conduct constituted professional misconduct and reprimanded Wood. In imposing sanction, the Tribunal had regard to the 12-months that had elapsed since Wood had surrendered his registration and that a period of disqualification for 12 months met the protective purpose of sanction. Whilst Mr Wood have been involved in the proceeding to the extent of filing a response and agreeing on a statement of agreed and disputed facts, he did not participate further in the proceeding and did not attend the hearing.

[38] In *Health Ombudsman v Jolley*,[29] Ms Jolley gained registration in 2014. Whilst she was employed and worked as an enrolled nurse at the Princess Alexandra Hospital,

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24 Section 4(2)(c) *Health Ombudsman Act 2013*.
25 [2019[ QCAT 35.
26 [2019] QCAT 173.
27 [2014] QCAT 161.
28 [2019] QCAT 35.
29 [2019] QCAT 173.

Jolley had a direct treating relationship with a male patient who had a history of mental illness, including post-traumatic stress disorder. Shortly after the patient's discharge from the hospital Jolley accepted a 'Facebook friend request' from him. They subsequently met and had lunch. When he was re-admitted she sent him a message to say because he'd been readmitted contact must cease. Even so, whilst he was still in hospital she sent him a text asking him to have coffee with her whilst he was on short release from hospital. After his discharge, contact continued and after a few weeks they developed a physical relationship including hugging, kissing and sleeping in the same bed together naked. In addition, Jolley breached patient confidentiality by disclosing information about other patients to the male patient. The inappropriate relationship lasted until March 2016. The relationship deteriorated and the patient sent threating calls and messages to Jolley. Jolley reported her conduct to her supervisors and ultimately her employment was terminated. The respondent subsequently gained employment at a private hospital in January 2017 and her position was elevated to registered nurse after her graduation in April 2017. The Nursing and Midwifery Board imposed conditions on her registration requiring supervisory reports to be submitted every 3 months. These conditions were removed in December 2017 after the Board had two satisfactory supervision reports. In July 2018 the respondent was employed as a nurse on a full time basis at the Metro South Health Service and had maintained employment since that time. The Tribunal found that the respondent had a full understanding of and insight of and insight into her conduct, she had sought and maintained psychological support and treatment and developed coping mechanisms. Since the conduct she undertook a 2-day intensive professional boundaries course and completed a professional boundaries and ethics course. The Tribunal found that given her youth, the steps already taken and her insight, that a period of suspension was unnecessary. It observed it was disappointing that young graduates were placed in difficult roles without support or mentoring.

[39] In *Nursing and Midwifery Board of Australia v Tainton*[30], Tainton was a nurse employed by Queensland Health at the Woodford Correctional Centre. The patient was a prisoner serving life imprisonment. Tainton and the patient exchanged five (5) letters by post and made a number of telephone calls to each other. The relationship never became physical, and no benefits were exchanged or offered to the patient. Tainton demonstrated insight and remorse with respect to her conduct and she had surrendered her nursing registration more than 2 years prior to the Tribunal's decision. Tainton was disqualified from applying for registration for three (3) months. The applicant limits its reliance on this authority to showing an example that there can be a suspension in the case of a non-physical relation constituting a boundary violation.

[40] In addition to the authorities from the applicant, the respondent referred the Tribunal to *Health Ombudsman* v *Bothwell*[31] and *Health Ombudsman* v *Kimpton*[32].

[41] In *Health Ombudsman* v *Bothwell*[33], Bothwell was an enrolled nurse employed at the Prince Charles Hospital (**PCH**). The patient was admitted in the Thoracic Ward of the PCH for cystic fibrosis and suffered from depression. In the period 2012 to

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30 [2014] QCAT 161.
31 [2020] QCAT 393.
32 [2018] QCAT 405.
33 [2020] QCAT 393.

2014, the patient received direct nursing care from the respondent. Sometime in 2012, the patient gave Bothwell his mobile phone number and they began texting each other. This developed into a friendship, which involved meeting outside the hospital, and ultimately developed into a consensual romantic and sexual relationship which continued from 2012 until the end of 2015. In late 2015 the relationship ended. In March 2016, Bothwell learned that the patient was in a relationship with a woman he met in the PCH ward. Over a period of weeks, Bothwell contacted this woman on Facebook and sent various messages including some of a threatening nature.

[42] Bothwell later recognised the complete inappropriateness of her conduct and expressed remorse over her actions. In terms of sanction, Bothwell was required to complete a professional boundaries course within 12 months. She was not subjected to a suspension.

[43] The Tribunal notes in respect of Bothwell that, whilst the relationship went for 3.5 years, the Tribunal found there were significant mitigating factors in that case:

(a) the parties were of similar ages, and the relationship was consensual and not initiated by the respondent;

(b) the respondent had made the notification of the relationship and expressed remorse (although some aspects of her initial notification were false); and

(c) the respondent had lost her job and had gone bankrupt because of the conditions imposed on her.

[44] At [39] the Tribunal, constituted by Judicial Member Robertson, after reviewing the authorities cited to it including *Jolley* and *Wood* observed: "*A fair analysis of these various cases does not support the proposition that in every case where a health practitioner engages in sexual boundary violations with a patient, during or after the cessation of the therapeutic relationship, a cancellation or a suspension should always follow*". The Tribunal viewed a suspension as punitive rather than protective.

[45] In *Health Ombudsman* v *Kimpton*[34], Kimpton was an enrolled nurse of 23 years service. He was employed at The Park - Centre for Mental Health Research, Treatment and Education (**Park**), forming part of the West Moreton Hospital and Health Service from 1989. In 2011 the 27 year old patient was transferred from the Townsville Women's Correctional Centre (**TWCC**) to the Park under an Involuntary Treatment Order where she met Mr Kimpton who was then 54.

[46] The patient was experiencing severe mental health problems including schizophrenia, post-traumatic stress disorder and a major depressive episode. Kimpton was, from time to time, assigned to observe the patient and he contributed to aspects of her patient care as delegated, though he was not involved in managing her treatment or in administering medications. After he gave the patient his mobile number, she called him almost daily over a 3 year period from the TWCC. They wrote letters to each other and he regularly sent her money in jail. Whilst it was agreed Kimpton commenced a personal relationship with the patient and at one stage, both parties referred to each other as partners, there was no sexual aspect to the relationship. The Tribunal found that it was not exploitative, but rather

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34 [2018] QCAT 405.

completely supportive and there was no evidence of harm to the patient. The personal relationship commenced, the Tribunal found, after the treating relationship ceased. Kimpton was subsequently removed from the ward and management reminded him about being careful about boundaries with patients. The Tribunal determined that Kimpton's conduct in these proceedings, viewed against the background of an otherwise unblemished career, his insight into his conduct together with the nature of the relationship were all mitigating factors to which the Tribunal must appropriately have regard. It was found he had no training in relation to ethics and boundary issues before the offending, and he'd taken steps to do so after. The Tribunal considered the finding of professional misconduct together with a reprimand amounted to a public denunciation of Kimpton's conduct and he was not subject to a suspension.

[47] Whilst the Tribunal accepts the authorities referred to by the parties demonstrate that a range of sanctions is possible, depending on the circumstances of a particular case, where nurses engage in relationships with patients, the Tribunal was concerned that the authorities, other than *Tainton*, all involved respondents who were enrolled nurses, where registered nurses have more significant education and training requirements.

[48] More significantly though, the Tribunal notes that none of the cases referred to involved a respondent in the position of the respondent in this case, where there is medical evidence that a psychiatric condition which he had at the time of the inappropriate relationship had a direct causal link to his actions in respect of Patient A.

[49] In this case the factors for the Tribunal considers are relevant when determining what sanction is appropriate are:

(a) the conduct was serious and occurred during the course of the therapeutic relationship as well as after it. Patient A was highly vulnerable and known to the respondent to be so. He was part of her treating team for a significant period;

(b) accessing the records of Patient A and conveying to her information ahead of that which was being conveyed to her by those who were treating her was not apt to assist Patient A to adjust to potential changes coming to her residential situation;

(c) the physical intimacy aspects of the relationship were limited, and the case proceeds on the basis that although the conduct involved hugging and kissing, the relationship was not otherwise a sexual one. It was also one where the feelings of the respondent and Patient A were mutual. The duration of the relationship was in the order of 2 months or less;

(d) there was a 17 year age gap between the respondent and Patient A;

(e) the respondent must have appreciated, to some degree, that the relationship was inappropriate in circumstances where he was taking steps to drop Patient A off several streets away from the CCU after their outings, to avoid detection;

(f) it was Patient A's disclosure which brought the end of the relationship about, not disclosure of it by the respondent;

(g) there was evidence of specific harm to Patient A in the significant disturbance of her already fragile mental state and the loss of her existing therapeutic relationship with CCU staff at the time;

(h) the respondent had no prior notification history;

(i) the inappropriate personal relationship occurred against a factual backdrop that in the months preceding him commencing work at the CCU, his marriage had failed, he had lost access to his children as they had moved away from where he was living and he had been homeless for a period of about a month sometime in the period between July and September 2017. The respondent had sought assistance from staff at his employer (including his team leader) having reported he was struggling emotionally. He had been referred to the Employee Assistance Programme and private health practitioners, but his condition did not improve;

(j) the psychiatrist's opinion that:

  (i) he was suffering from a major depressive disorder at the time (having had mental health issues since the late 1990s). This major depressive disorder likely impaired the respondent's judgment and the social isolation and marital breakdown also made him more vulnerable and open to the affectionate attentions of Patient A;

  (ii) he showed intellectual insight into his offending;

  (iii) he was at low risk of re-engaging in the behaviour that is the subject of the referral;

  (iv) he is a person who remains vulnerable by reason of a number of factors in his developmental history, and his mental health, his need for ongoing treatment and risks with social isolation;

  (v) he is fit to work as a registered nurse;

  (vi) he would not be fit to work in the health industry in the mental health area but it would be more appropriate that he works in an area such as aged care where the risk of boundary violations is less likely to occur;

  (vii) if he was to work in these areas, it would be appropriate that it is in approved position with monitoring by the AHPRA and supervised practice with feedback to AHPRA;

(k) from September 2019 the respondent did not work as a registered nurse for 17 months. Indeed he did not work at all. This was a self-imposed removal from the workforce at a time when his mental health was poor. The regulator did not impose any interim conditions on his ability to work. The Tribunal accepts that this says something about his insight that he was not working at the time when he was likely of most significant risk to the public;

(l) the respondent has done a boundaries course of his own volition;

(m) the respondent has recently remarried and he sees his children weekly;

(n) the respondent has been working as a nurse since about March 2021 and is presently working as a registered nurse in the aged care sector. The applicant accepts he was worked without violations since he resumed work;

(o) The objective signs of the respondent's remorse are that:

(i) the respondent cooperated with the investigation and made frank admissions in respect of aspects of allegation one, a number of which allowed the extent of the conduct to be better understood. He also made admissions about the matters in allegation 2, as to the number of times the records were accessed and as to explanations for that access; and

(ii) the respondent has accepted the characterisation of his actions as professional misconduct and the matter has proceeded before the Tribunal on agreed facts and largely agreed submissions on sanction.

[50] Having regard to Dr Prior's opinion that the respondent's mental illness likely impairing his judgment, the Tribunal finds that the applicant's acceptance that this renders the respondent someone where considerations of general and specific deterrence are somewhat less relevant as proper.

[51] This is a finely balanced case. Overall, weighing the above factors, the Tribunal is of the opinion that:

(a) the protection of the public will be best served by requiring the respondent to obtain approval of the places where he works for a period of 3 years from the date of this order;

(b) given his particular personal circumstances, and the direct connection between his mental illness and his impaired judgment and the conduct the subject of the referral, that to impose the sanction of a suspension at this time would be more a punitive response than one which will best protect the public. In that regard it is noted that:

(i) the Tribunal will impose a reprimand which, as the authorities recognise, is not a trivial sanction and will serve the purpose of public denunciation;

(ii) the conduct occurred in late 2018 and early 2019; and

(iii) the respondent did not work for seventeen months from September 2019, much closer to the time when his judgment was impaired by reason of his mental health. This has relevance, in that, from the position of public protection, he was not working when he presented a greater risk to the public than he does now. The respondent has sought and received treatment in the intervening period.

[52] The Tribunal has derived considerable assistance from the assessors and thanks them for their thoughtful engagement and assistance.

**Orders**

[53] Balancing all these features, the Tribunal makes the following orders:

1. Pursuant to s 107(2)(b)(iii) of the *Health Ombudsman Act 2013* (HO Act) the respondent has behaved in a way that constitutes professional misconduct.

2. Pursuant to s 107(3)(a) of the HO Act the respondent is reprimanded.

3. Pursuant to section 107(3)(b)(iii) of the HO Act, the respondent must not practise as a registered nurse in an Authorised Mental Health Service;

4. Pursuant to section 107(3)(b)(iii) of the HO Act, the respondent may practise only in place(s) of practice approved by the Nursing and Midwifery Board for a period of three years from the date of this order. For the purpose of this order, 'practise' is defined as any role, whether remunerated or not, in which the individual uses their skills and knowledge as a registered nurse in their profession. It is not restricted to the provision of direct clinical care and includes using the knowledge and skills of a nursing profession in a direct non- clinical relationship with a client, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe, effective delivery of services in the nursing industry.

5. Each party bears its own costs of the proceedings.