MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 291/03/110D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **THOMAS PAUL O'FLYNN** medical practitioner of Invercargill

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Miss S M Moran (Chair)

Dr L Ding, Dr C P Malpass, Mrs H White, Dr L F Wilson (Members)

Ms G J Fraser (Secretary)

Ms H Hoffman, Mrs P Morgan and Mrs G Rogers (Stenographers)

Hearing held at Invercargill on Monday 29 March through to and including Friday 2 April 2004 and Monday 5 April April 2004

APPEARANCES: Ms K P McDonald QC and Ms T M Baker for the Director of Proceedings ("the Director")

Mr H B Rennie QC and Mr A Lewis for Dr T P O'Flynn

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Introduction

1. Dr O'Flynn is a consultant psychiatrist. On 9 March 1998 he commenced employment with Southern Crown Health Enterprises Limited (Southern Health) which later became the Southland District Health Board (sometimes referred to as Southland Health). However, to avoid confusion the Tribunal has referred to the former and current entities throughout this decision as "Southern Health". Dr O'Flynn was employed as specialist psychiatrist to the Child Adolescent and Family Service (CAFS) of Southern Health. He was subsequently appointed as Clinical Director of Southern Health's Mental Health Services and Director of Area Mental Health Services (Area Director) for Southland with effect from 1 July 1998.

2. In October 2000 Dr Peter Fisher was employed as a Medical Officer Special Scale (MOSS) in the Psychiatric Department of Southland Hospital, Invercargill (sometimes referred to as Kew Hospital). To avoid confusion the Tribunal has referred to the hospital throughout this decision as Southland Hospital. Dr Fisher had previously been employed by Southern Health in the period 1992 to 1999. He had also been engaged as a locum MOSS for two weeks in May 2000.

3. In February 2001 Mark Burton (Mark) was 19 years old. He had been living with his parents and siblings in Queenstown. He had been diagnosed as having schizophrenia with a history of alcohol and cannabis abuse. His first contact with mental health services was in July 1998 when his mother sought help from the Queenstown Community Mental Health team. Contact continued throughout 1998, 1999 and 2000. His treatment included medication. Mark had also been admitted in June/July 2000 for four weeks as a voluntary patient to Ward 12 of the In-patient Unit of Southern Health's Mental Health Services at Southland Hospital, Invercargill.

4. In January 2001 Mrs Paddy Burton and Mr Trevor Burton (Mark's parents) became concerned about Mark's anger and aggression towards his mother and his lack of co-operation. They were concerned also about his use of alcohol and cannabis.

5. During the morning of 10 February 2001 Mark's conduct was highly disturbed and of significant concern to his family. Eventually, Mark agreed to travel that day with his father to Invercargill where he was admitted (again) as a voluntary patient to Ward 12 of Southland Hospital. Dr Fisher admitted Mark in the presence of Mr Burton.

6. On 11 February 2001, Mr Burton wrote a lengthy letter to the hospital setting out Mark's history. He stated that should Mark be discharged from hospital while still holding certain delusional views he could cause death or serious injury within the family and signalled in emphatic terms his concern in particular for the safety of Mrs Burton and Mark's younger brother should Mark return to the family home. He added that he was making those observations not only as a parent but also as a police sergeant with over 28 years experience observing violent behaviour as a front line policeman.

7. On 22 March 2001 Mark was placed on a week's trial leave from Southland Hospital and was discharged on 30 March 2001.

8. During the period 10 February 2001 to 30 March 2001 Mark was under the care and management of Dr Fisher.

9. During the early hours of 31 March 2001, Mark, having travelled from Invercargill to his parents' home at Queenstown, attacked and killed his mother, Mrs Paddy Burton. Mark was subsequently arrested and charged with the murder of his mother. Following a trial before a Judge and Jury in the High Court in August 2001, Mark was found not guilty of murder by reason of insanity. He was then committed as a special patient under the Criminal Justice Act 1985.

10. Following the death of Mrs Burton, Southern Health commissioned Dr Bridget Taumoepeau, Consultant Psychiatrist practising in Wellington and Porirua, to undertake a clinical audit of the care provided to Mark by its Mental Health Service inpatient unit. Dr Taumoepeau's report was concluded in August 2001 and publicly released in September 2001. It made a number of recommendations.

11. On 4 October 2001, the Health and Disability Commissioner (HDC) of his own initiative announced terms of reference for an inquiry into the quality of care provided to Mark by Southern Health's inpatient Mental Health Service.

12. On 5 October 2001 as a result of his concerns about the care Mark received while an inpatient in Ward 12 and his subsequent discharge, Mark's father, Mr Trevor Burton, laid a complaint with the HDC's office.

13. A Coroner's Inquest was held between 26 November 2001 and 4 December 2001. The Coroner's Findings were released on 12 April 2002.

14. The HDC's provisional report was released in June 2002 and his final report thereafter which made a number of recommendations.

15. On 5 June 2003 the Director of Proceedings laid disciplinary charges against Dr Fisher before the Medical Practitioners Disciplinary Tribunal (the Tribunal) (with differently constituted members from the present Tribunal) pursuant to the Health & Disability Commissioner Act 1994. Following a defended hearing in Invercargill and then in Auckland in November 2003, the Tribunal found Dr Fisher guilty of professional misconduct in seventeen respects regarding his failure to adequately assess and review Mark's mental state, the risks he posed, and the treatment and management. The Tribunal also found that Dr Fisher failed to adequately document and record his assessments, reviews, and treatment plans for Mark during the period in question. The Tribunal suspended Dr Fisher's registration for a period of six months, imposed conditions on his ability to practise psychiatry and psychological medicine in New Zealand and ordered him to pay 50% of the Tribunal's costs and 40% of the prosecutions costs.

16. On the issue of causation, that Tribunal held:

> *Dr Fisher's management of Mark became the subject of careful scrutiny because the day after he was discharged Mark returned to Queenstown and killed his mother. The enquiries which followed ultimately resulted in the laying of the disciplinary charges against Dr Fisher which the Tribunal has now heard and determined. It needs to be stressed that although the Tribunal has found Dr Fisher's management of Mark was seriously deficient in a*

> *number of significant respects it must not be thought that there is a causal link between Dr Fisher's errors and the tragic death of Mrs Burton. The Tribunal's decision should not be construed as suggesting Dr Fisher's acts and omissions caused Mrs Burton's death.*

17. It was not advanced during the present hearing that any act or omission on the part of Dr O'Flynn caused Mrs Burton's death and nothing in this decision should give rise to that suggestion.

18. The Director of Proceedings, on 5 June 2003, also laid a charge of professional misconduct against Dr O'Flynn in that in his role as Clinical Director for Southern Health Mental Health Services he failed to ensure that Dr Fisher was adequately supervised and/or failed to adequately assess Dr Fisher's experience and/or competence and thereby determine the scope of Dr Fisher's unsupervised practice to ensure that he met appropriate clinical standards of care.

19. Dr O'Flynn defended the charge before this Tribunal. The hearing took place over six days during which the Tribunal received some 20 written briefs of evidence-in-chief, heard cross examination which is contained in some 600 pages of transcript and received and considered some four volumes (both bound and loose) of exhibits.

20. Following the conclusion of the hearing, the members of the Tribunal stayed at Invercargill for a further period of time in order to consider all of the evidence, both oral and written, the submissions of counsel, and to deliberate. The Tribunal reached the unanimous decision that the charge against Dr O'Flynn should be dismissed.

The Charge

21. The charge is as follows:

> *The Director of Proceedings, pursuant to sections 102 and 109 of the Medical Practitioners Act 1995 charged Dr O'Flynn that between 1 May 2000 and 30 March 2001, while in his role as Clinical Director for SDHB [Southland District Health Board] Mental Health Services which was providing clinical services to Mark Burton between 10 February 2001 and 30 March 2001, Dr O'Flynn, being a medical practitioner, acted in such a way that amounted to professional misconduct in particular he:*

(1) Between 10 February 2001 and 30 March 2001 failed to ensure that Dr Peter Fisher, Medical Officer Special Scale, the clinician responsible for Mark Burton's care, was adequately supervised and/or

(2) Between 1 May 2000 and 30 March 2001 failed to adequately assess Dr Peter Fisher's experience and/or competence, and thereby determine the scope of his unsupervised practice to ensure that he met appropriate medical standards of care.

The conduct alleged in particulars (1) to (2) either separately or cumulatively amounts to professional misconduct.

Summary of Prosecution's Case

22. The prosecution's case was ably explained by Ms McDonald, Counsel for the Director of Proceedings, in her opening.

23. Ms McDonald stated that part of Dr O'Flynn's responsibility as Clinical Director was to have systems to ensure adequate support and supervision. It was the prosecution case that there was a failure by Dr O'Flynn to provide clear directions or guidelines regarding the performance of Dr Fisher. The Director stated that there was no systematic review of the performance of Dr Fisher; there was no monitoring of his practice; that the sole occasion for medical staff to review the practice of colleagues and to offer support and guidance were weekly review meetings; and there was no effective directive from Dr O'Flynn that the senior medical staff should attend those, and he himself attended only two of the five meetings which occurred during the period of Mark's inpatient care.

24. Counsel stated that more rigorous supervision should have been arranged for Dr Fisher and that Dr O'Flynn was responsible for ensuring such supervision and support were provided.

25. Counsel also stated that safe practice suggested Dr Fisher should have been supervised in some appropriate manner, especially if there were concerns about prior performance or if the standard of recent performance was unknown.

26. Counsel further stated that an expected function of a Clinical Director in determining whether a person is suited to a particular role is to ensure that person had the skills and

requirements for the role, and to have systems in place to monitor and to support. Dr O'Flynn is said to have failed to do that in relation to Dr Fisher.

Summary of Defence's Case

27. Mr Rennie, Counsel for Dr O'Flynn, outlined the defence's case when he opened.

28. Mr Rennie emphasised that the charge related only to Dr O'Flynn's role as Clinical Director, and not to his practice as a consultant psychiatrist, in respect of which no challenge was made.

29. The charge related only to one member of staff, namely, Dr Fisher.

30. Mr Rennie indicated that he would call evidence relating to Southern Health's previous premises, matters of funding, waiting lists and patient numbers. He stated that the evidence would be adduced not to excuse any allegation made against Dr O'Flynn, but so that the allegations could be judged in the correct context.

31. In relation to the specific charges, Mr Rennie referred the Tribunal to the settled legal principles, and emphasised that it was for the prosecution to prove its case, including establishing that the allegations made constituted professional misconduct.

32. He questioned the value of expert evidence in this type of case. He submitted that there could be no experts in the matter of personal judgment.

33. Turning to the facts, Mr Rennie referred to "five key elements" in this matter.

34. First, he referred to the fact that these events occurred in Southland. He stated that there are no neighbouring hospitals to assist the small team based at Southland Hospital, apart from one in Christchurch and Dunedin.

35. Secondly, he referred sympathetically to Mark and his family.

36. Thirdly, he referred to Dr Fisher, who was not to be called to give evidence. He emphasised that although Dr Fisher was appointed in 2000, he had previously worked for five years at Southland Hospital.

37. He questioned the appropriateness of the prosecution's failure to call certain persons who had knowledge of Dr Fisher.

38. As a result of the prosecution's failure to call those persons, Mr Rennie submitted that the only direct evidence about Dr Fisher would be that of Dr O'Flynn. (As it transpired, the Tribunal also heard evidence from Dr A.)

39. Mr Rennie then commented about the fourth "key element", Dr O'Flynn himself. He said Dr O'Flynn would explain how he worked with, managed and supported staff at Southern Health.

40. He said that Dr O'Flynn and another Southland psychiatrist would explain the "extraordinary, unanticipated and improbable" error Dr Fisher made in his assessment of Mark. He referred to the "hidden flaw" in Dr Fisher, that this tragedy had brought into the open.

41. This "hidden flaw" was not able to be ascertained from information provided to Dr O'Flynn about Dr Fisher's career history from references and other sources.

42. Mr Rennie then referred to the fifth "key element", the HDC investigation following which the present charge was laid.

43. Mr Rennie criticised the investigation as inadequate, incomplete, and providing no adequate basis for the allegations against Dr O'Flynn.

Witnesses for the Director of Proceedings

44. The Director of Proceedings called eight witnesses.

(a) Trevor Francis Burton, the husband of the late Mrs Paddy Burton and father of Mark Burton.

(b) xx who was a mental health needs assessor in 2001 and who worked out of the Social Work Department at Southland Hospital. xx's name is the subject of a suppression order. xx is to be referred to as a mental health needs assessor.

(c) xx, a nurse who worked in the Community Mental Health Team at Southland Hospital during the relevant period. xx's name is the subject of a suppression order. xx is to be referred to as a Community Mental Health Nurse.

(d) Ms X who was the xx at the relevant time. Ms X's name is the subject of a suppression order. Ms X is to be referred to as Ms X, a former member of staff.

(e) xx, a drug and alcohol counsellor employed by Southern Health at the relevant time. xx's name is the subject of a suppression order. xx is to be referred to as a drug and alcohol counsellor.

(f) Tania Maureen Turfrey, the Registrar for the Medical Council of New Zealand.

(g) Graham Wilfred Mellsop, a Professor of Psychiatry who was called as an expert.

(h) Murray David Patton, a psychiatrist who was asked by the Health & Disability Commissioner in October 2001 to be the psychiatric expert adviser on a panel engaged as part of the enquiry into Southern Health's Mental Health Services following the death of Mrs Burton. Dr Patton was also called as an expert.

Witnesses for Dr O'Flynn

45. Dr O'Flynn gave evidence on his own behalf and called nine witnesses.

(a) Dr Gershu Chandy Paul, Chief Executive Officer of Southern Health.

(b) Mr Michael James Fitzgerald, General Manager of Mental Health Services for Southern Health.

(c) Mrs Glennis Margaret Areaitti, the Administration Officer for the CAFS of Southern Health.

(d) Mr Y, a counsellor. Mr Y's name is the subject of a suppression order. Mr Y is to be referred to as a Mental Health Counsellor.

(e) Dr A, a Senior Consultant Psychiatrist employed by Southern Health working in the xx. Dr A's name is the subject of a suppression order. Dr A is to be referred to as a Senior Consultant Psychiatrist.

(f) Heather June Power who was employed by Southern Health at the CAFS as an Education Liaison Officer at the relevant time.

(g) Dr Duncan Malcolm Roy, a Consultant Psychiatrist of Wellington.

(h) Dr Cameron John Ryan a Registrar in Psychiatry presently with the Canterbury District Health Board.

(i) Dr Anna Thornton Dyzel a vocationally registered General Medical Practitioner of Hokitika.

The Context

46. The Tribunal accepts Mr Rennie's submission that it is appropriate to consider the background so that the charge can be fairly considered in context.

47. We now refer to that evidence.

48. As stated, the matters set out below (which formed part of the evidence and which the Tribunal accepts) were not provided to excuse any allegations made against Dr O'Flynn but so that the allegations could be judged in context.

49. Dr O'Flynn is a qualified and registered clinical psychiatrist with over twenty years as a clinical psychiatrist both overseas and in New Zealand. His area of particular interest and expertise is in child and adolescent psychiatry. He was first registered in New Zealand provisionally on 8 April 1998 and thereafter gained general and vocational registration on 14 May 1998.

50. Dr O'Flynn graduated in 1979 from the National University of Ireland with Bachelor degrees in Medicine and Surgery. He gained membership of the Royal College of Psychiatrists, London, in 1984. The Tribunal has seen his curriculum vitae. It is not necessary to traverse his qualifications and experience. Suffice to say, as at June 1997 he held and had held for five years the position of Chief of Psychiatry at Fort McMurray in Canada. At that time he visited New Zealand and considered the possibility of taking up employment as a specialist child and adolescent psychiatrist in Invercargill. The prospect of employment in Invercargill was attractive for family reasons as both he and his wife wished to familiarise themselves with the region, the professional opportunities and whether it would be a suitable home for their four children. (They have since had a fifth child born in Invercargill).

51. Dr O'Flynn told the Tribunal that during this visit it was apparent that Southland Mental Health Services faced some shortages of staff and resources. He said this was not uncommon in psychiatric services. However, when he commenced employment in March the following year he found the situation was much worse than he had realised for which there were many reasons including significant underfunding and a serious shortage of personnel. The Service was demoralised, split over a number of physical premises (some of which were out-dated), and some particular requirements were not being met at all.

52. Mental Health Services Southland provides mental health service for the Southland area serving the city of Invercargill, and the smaller towns of Gore and Queenstown, the extensive rural area around them involving a permanent regional population of about 108,000 spread over a wide geographical area.

53. In-patient services are provided at Southland Hospital (formerly Ward 12) where a further range of specialist, outpatient and community services is based. There is a Child and Adolescent Service and a small Forensic Service.

54. The Community Service is based on Community Mental Health Teams, the main teams and associated services being based in Invercargill. At the time relevant to this charge (February/March 2001) they were located in several different parts of Invercargill.

55. There are additionally small teams in Queenstown and Gore, and there are satellites at Te Anau, Tuatapere, Riverton and Bluff.

56. In March 1998, on taking up the position of Child and Adolescence Psychiatrist at CAFS, Dr O'Flynn learned that there was a waiting time of one year from first referral to being seen at the service. There had also been a significant number of teenage suicides.

57. Dr O'Flynn took over a caseload of some 200 children who, prior to his arrival, had been considered to have behavioural problems requiring medication. He said it took him some 12 months to bring the situation under control and divert the majority of those children into therapies which were not dependent on long term medication.

58. Dr O'Flynn set out to close the waiting list and said that by working extra hours and with great support from key staff the period was soon reduced to one month at worst with urgent cases usually seen within 24 hours.

59. He told the Tribunal he set about establishing Child and Adolescent Clinics in Queenstown, Te Anau and Riverton which he attended monthly. He undertook home visits for special cases.

60. He established liaison with most schools giving particular attention to those where suicide and para-suicide were perceived problems. He reinstated the practice of school visits in order to meet with each child patient and their parents and teachers and to provide open access between himself and the counsellors at those schools. He stated all of this was time-consuming but is a core part of such therapies.

61. The psychiatrists employed by Southern Health provide the only psychiatric services in Southland with the single exception being an occasional clinic by a visiting Dunedin psychiatrist in private practice. Dr O'Flynn explained that unlike larger centres, which have a variety of services provided to them publicly, privately and through community and educational organisations, Southland is wholly dependent on the CAFS service which he led.

62. Further, Southland's only regional child psychiatric beds are located in Christchurch which are funded from Southland's grants but are of very limited practical use due to the distance.

63. He told the Tribunal that by 1999 he had an active caseload of approximately 300 patients and their families, rising after that to 400. He provided back-up and second opinions to the multi disciplinary team as well as 24 hour on call availability for mental health emergencies involving children or adolescents. Dr O'Flynn explained that until 2003 he was the only psychiatrist (and the only medical staff member) employed in CAFS. The work of the CAFS by itself was in excess of a full time position for one psychiatrist.

64. Dr O'Flynn said he became aware of a number of adult patients with long term psychiatric conditions who were suffering from the consequences of repeated changes of specialists as a result of a succession of psychiatrists who were passing through or took up only short term employment at Southland. This instability in the patients' specialist was reflected in deterioration in their own welfare where past gains in health were lost.

65. Dr O'Flynn said he considered that what was needed was continuity of care. Frequently his only means of achieving this was to undertake the task himself. He therefore had, in addition to his CAFS caseload, an adult caseload approaching a full-time position in its own right.

66. Added to this was the further responsibility for the forensic cases as there was no psychiatrist available other than Dr O'Flynn to undertake them.

67. At the time of Dr O'Flynn's appointment in March 1998, Dr Cowley was the Director of the Area Mental Health Service and the Clinical Director for Southern Health's Mental Health Services. Dr O'Flynn said from his own observations Dr Cowley did what he could but there were serious problems. Later in 1998, Dr Cowley was to be transferred to the position of Director of Medical Services of Southern Health.

68. However, Dr Cowley was unable to take up his new position until someone could be found to fill the roles of Clinical Director and of Area Director. Dr Cowley asked Dr

O'Flynn if he would do so. Dr O'Flynn said that, generally speaking the roles should be kept separate as there can be some inherent conflict of interest. He did not see either appointment as a career move or a promotion but as there was no other psychiatrist available to undertake these additional roles, he reluctantly agreed.

69. In undertaking these additional roles, Dr O'Flynn told the Tribunal he hoped to protect the gains he had made in his own area (CAFS) while improving other areas. He intended to reduce his duties as new permanent appointments of psychiatrists were made.

70. He did have apprehensions about the additional workload this would impose on him; and considerable apprehension about a number of problems within the Service, including the fact that it was consistently understaffed. This caused the Service to practise in an increasingly defensive way. He also told the Tribunal that the inpatient unit was architecturally unsafe, and a depressing place for the staff in which to work.

71. Dr O'Flynn stated that he did not have apprehensions about what he saw as being the "core tasks". He saw his role as improving and maintaining good clinical delivery to the population which he served. He saw there were opportunities within the Service to bring about positive changes.

72. As Dr Cowley was moving to a position with a major new workload, Dr O'Flynn did not receive any formal handover; there was no transitional period; there was no interview which might enlighten him as to what was expected of him in the role; there was no clear definition of what was required; and he was required, of his own initiative, to identify, and to do, whatever needed to be done.

73. Dr O'Flynn said that while his previous Canadian experience was of some assistance, he accepted he was taking over a service with serious problems.

74. At the time of Dr O'Flynn's appointment, Southland Mental Health Service had about 150 staff.

75. Dr O'Flynn told the Tribunal that in his role as Clinical Director he provided clinical backup and consultation to staff, saw patients for whom no other doctor was available on a daily basis and dealt with any other problems which arose. He said he was available to all staff 24 hours a day, 7 days a week and, in practice, they availed themselves of his availability.

76. Dr O'Flynn told the Tribunal that, at all relevant times, Southland Mental Health Services was consistently short of psychiatrists. It was also short of staff at medical officer levels. He said he had to work long hours to fill gaps in all areas of the service. On occasions, for example, he was the only psychiatrist available to Ward 12 (the inpatient ward) or the community and forensic teams. These various roles were carried out to fill gaps alongside his CAFS work and his roles as Area Director and Clinical Director.

77. In endeavouring to meet these various roles and responsibilities, Dr O'Flynn said he followed two key principles: (a) giving priority to where the need and the risk was greatest (which generally meant putting patient needs at all times as the absolute first priority, and (b) ensuring that it was not the patient who suffered as a result of these problems.

78. In Dr O'Flynn's words, that was the reality of the situation which he faced.

79. Dr O'Flynn was given to understand that the position of Clinical Director was equivalent to 0.1 of a full time position which assumed the role could have been undertaken in one half day a week.

80. However, the Tribunal is satisfied on the evidence and on Southern Health's own position definitions, Dr O'Flynn was undertaking the work of the equivalent of 2.3 full time positions. He was performing as a full time child and adolescent psychiatrist which equated to one full time position; as an inpatient and forensic psychiatrist which equated to a further full time position; and as Clinical Director and Area Director which equated to .3 of a full time position.

81. The Tribunal heard evidence that after being appointed as Director of Medical Services of Southern Health, Dr Cowley established an audit of the Mental Health inpatient unit. It

was intended to provide a basis for seeking new facilities. The audit team was headed by the District Inspector, Mr Murdoch and reported in April/May 1999. A copy of the report (known as the Murdoch Report) was produced to the Tribunal.

82. The Murdoch Report concluded that the inpatient unit was totally outdated and inadequate to provide inpatient Mental Health Services and that as a matter of urgency the unit needed to be replaced with a purpose built facility. The report referred to current risks and identified hazards. It referred to the shortage of psychiatrists and the fragile type of arrangement generally relying on short term locums which resulted in a lack of continuity of care.

83. The report identified shortages of other medical staff and the need to create a senior nursing position so as to provide professional leadership and support to the nursing staff of the Service.

84. The audit team were of the view that the Clinical Director (Dr O'Flynn) was *already overloaded in his clinical workload and [had] insufficient time to develop an effective leadership,* and that *as a result of the lack of the Clinical Director's time the Business Manager [appeared] to be making resource decisions without adequate clinical input.*

85. When referring to this part of the Murdoch Report Dr O'Flynn stated that this put on formal record to the District Health Board what Dr Cowley already knew from his experience in the position – the burden he was carrying was such that it affected his ability to also carry out business and management work.

86. The Murdoch Report also stated that Southern Health had experienced considerable changes in its structure and personnel (involved in senior management positions) and those had had an adverse impact on the cohesion and continuity of service leadership, both strategic and operational.

87. Dr O'Flynn explained that in addition to these internal problems there was constant instability due to frequent changes being made at Government and Ministry levels.

88. There was further evidence as to background and context from other witnesses, namely, Mrs Glennis Areaitti, Ms Heather Power, Mr Y a Mental Health Counsellor, Mr Michael Fitzgerald, Dr A a Senior Consultant Psychiatrist, Dr Duncan Roy, Dr Cameron Ryan, and Dr Gershu Paul.

Mrs Areaitti

89. Mrs Glennis Areaitti is employed by Southern Health as the Administration Officer for CAFS.

90. Mrs Areaitti told the Tribunal that for the last 30 years she has worked as a medical secretary for surgeons and physicians, and most recently as Dr O'Flynn's medical secretary for the past 3½ years prior to his going on leave in October 2003.

91. She described to the Tribunal the caseload which Dr O'Flynn had to undertake upon taking up his appointment with Southern Health, the very long hours he worked, the fact that he always made himself available day or night if a patient were in crisis, the compassion which he exhibited for the patients and their families, the clinics which he conducted in the outreach areas and the achievements he made which, at times, was under very difficult conditions including the fact that for a significant period he had to work without a nurse at CAFS. She said his cellphone number was available to every mental health professional in the service, even when he was in Australia.

92. She retrieved the figures for Dr O'Flynn's patients in the period from 1 May 2000 to 31 May 2001 during which time he had 404 patients on his CAFS list. Additionally, he had a further 102 Mental Health Service patients admitted to the In-patient Unit during the same period.

93. Mrs Areaitti described Dr O'Flynn as an incredible doctor for whom she had much admiration for his dedication, commitment, loyalty and courage, and which had exceeded others for whom she had worked.

Ms Power

94. Ms Heather Power was employed in June 2000 by Southern Health at CAFS as an Education Liaison Officer. This was a new role which included setting up productive liaisons with schools and community groups across Southland, providing education about CAFS and often attending meetings as well as school meetings on behalf of Dr O'Flynn when he was unable to fit them in with his schedule.

95. She has been the Team Leader for CAFS since August 2002.

96. Ms Power stated that when she started work with CAFS in June 2000 it quickly became apparent to her that Dr O'Flynn had been forced to accept a huge caseload which at that time comprised over 300 clients ranging from the very young to late adolescent with many and varied mental health conditions.

97. She referred to the considerable achievements which Dr O'Flynn made in various aspects of the Service which she identified.

98. With regard to his CAFS role, she said that in order to accommodate the needs of all the young people and their families, Dr O'Flynn worked long hours, making himself available at all times of the day and night and quickly gained a reputation throughout the Southland community as a man dedicated to improving the mental health of young people.

99. She described the premises where staff at CAFS had to work as completely unsatisfactory. She said Dr O'Flynn never complained, never said "no" to staff, was always prepared to talk about matters after work, and always put others ahead of himself. Over and above this Ms Power stated Dr O'Flynn consistently provided his colleagues with support, mentoring, and encouragement, from whom they took great comfort. She said he never faltered in his endeavour to support, treat and advocate for the young people entrusted to his care.

Mental Health Counsellor (Mr Y)

100. Mr Y (name suppressed) is a mental health counsellor. Mr Y said that in 1998 he was seconded to work as xx for Southern Health in which capacity he undertook a wide variety of roles. In June 2000, he became a xx at CAFS and held that position until May 2001 when he left to undertake the same position he had previously held for one of the Community Mental Health Teams.

101. In his role with CAFS he came to know Dr O'Flynn. He said it became immediately apparent to him that Dr O'Flynn's workload was untenable; and that the clinical demand was overwhelming but it was not in Dr O'Flynn's nature to refuse helping wherever he could. In his observation Dr O'Flynn was always working late, at nights, and at weekends.

102. Mr Y said he was impressed that, without complaint, Dr O'Flynn continued to do his best to fulfil all of his different roles. He was obviously committed to keeping the Service running. The alternative was unthinkable and Dr O'Flynn led by example as they all worked to maintain the Service and move towards longer term solutions. He said Dr O'Flynn was not simply managing moment by moment in a reactive way, but rather was leading the team towards accreditation, new premises, and the provision of a full range of services. By enhancing those, the Mental Health Counsellor said that they increased their prospects of recruiting and retaining key staff.

Mr Fitzgerald

103. Mr Michael Fitzgerald has been the General Manager of Mental Health Services for Southern Health since October 2002. Prior to this he was the Patient Services Manager for Mental Health, having taken over Ms Nicki Kitson's responsibilities. He commenced employment with Southern Health in June 2002.

104. Mr Fitzgerald's present role encompasses not only Ms Kitson's former operational role but responsibility for funding, planning, contracting, and monitoring of mental health services across Southland covering both hospital and non-government organisations.

105. Prior to this, Mr Fitzgerald was locality manager for mental health in the southern region of the Health Funding Authority (HFA) and its successors from December 1999 until October 2001. The area he covered was Otago, South Canterbury and Southland and had similar responsibilities to those he now holds.

106. One of Mr Fitzgerald's tasks for the HFA was to monitor the progress which the Southland Mental Health Service was making towards implementing the recommendations contained in the Murdoch Report.

107. Mr Fitzgerald referred to the problems which the Murdoch Report had identified including the fact that Dr O'Flynn, as Clinical Director, was already overloaded in his clinical work and had insufficient time to develop an effective leadership. Mr Fitzgerald commented that it was a lot easier to identify the problems than to resolve them. He stated that Southland Hospital was finding it could not recruit psychiatrists and that despite constant advertising it was consistently understaffed.

108. According to Mr Fitzgerald, the recruitment and retention of staff is much better now than it was at that time. He said a considerable amount of effort had been put into recruiting doctors since he started with Southern Health and there is now a full complement of doctors. He commented that the construction and opening of a new inpatient unit has been a factor, and that the promotion of Southland by local authorities has also helped. However, in his opinion, the real improvement was a result of the sustained use of professional skills.

109. Counsel for the Director of Proceedings asked Mr Fitzgerald what he understood the reference under the heading "Leadership and Direction" at page 18 of the Murdoch Report which highlighted some concerns about staff feeling "leaderless". He said this related more to nursing staff than medical staff. The report had identified a need for the creation of a senior nursing position, which was created but at a later time.

110. Mr Fitzgerald said that while he was still at the HFA at the end of 2000 he reported that the issues, other than the unit's facilities and premises issues which he continued to report as dangerous, had been resolved.

111. He expressed the opinion that a significant contributor to this positive result was that Dr O'Flynn had proven to be effective as a Clinical Director. He said that under Dr O'Flynn's leadership, Southland Hospital Mental Health Services had turned around the quality issues. In addition to the internal management, he said Dr O'Flynn supported fully formal accreditation as a key aim for the service which was finally achieved in 2003. He said it would have been easy to have sought to defer accreditation (as did some other District Health Boards) on the grounds of resource and staff limitations but that Dr O'Flynn had higher standards. He said Dr O'Flynn had worked steadily throughout his time as Clinical Director to achieve sound governance within the service.

112. Mr Fitzgerald expressed the view that it was to Dr O'Flynn's credit that the Service was one of the first in New Zealand to gain both accreditation and certification which is something which has still not been achieved by some of the larger District Health Boards.

113. He assured the Tribunal that his view of Dr O'Flynn's achievements was not based on any personal friendship. To the contrary, he said that he had to carry out his former HFA role without the opportunity to deal directly with Dr O'Flynn. He dealt with other personnel including Ms Kitson. On the several occasions that he sought to see Dr O'Flynn when he went to Southland Hospital he did not have a meeting with him because Dr O'Flynn was always committed to clinical duties which were his daytime priority. On each occasion he met Ms Kitson who would refer the issues to Dr O'Flynn and arrange for responses from him or other administrative action. In Mr Fitzgerald's view this represented effective delegation as Mr Fitzgerald was still able to carry out all his duties but it reinforced for him the pressure which Dr O'Flynn was under as Clinical Director.

114. Mr Fitzgerald referred to the disparity in funding for Southern Health's Mental Health Service compared with other centres which was of concern to him when he worked at the HFA. He said that in the financial year 2000-2001 the highest paid hospital service was Otago and the lowest was Southland.

115. This funding, according to Mr Fitzgerald, generally put pressure on the Mental Health Service in Southland which flowed on to Dr O'Flynn. He gave by way of example, that the HFA at the beginning of 2000-2001 re-calculated the money to go to each hospital's

mental health service. As a result Southern Health received an additional $1 million but he later became aware that instead of it being used to fund more staff or to improve staff retention, it was used to reduce the hospital's operating deficit.

A Senior Consultant Psychiatrist (Dr A)

116. Dr A a Senior Consultant Psychiatrist (name suppressed) is a psychiatrist vocationally registered in New Zealand employed by Southern Health. [**Suppressed by order of the Tribunal**].

117. Dr O'Flynn, in Dr A's view, had a very difficult job as a Clinical Director with Southern Health. Dr A said this would even have applied had Dr O'Flynn had a full complement of staff. However, with the staff shortages, a difficult position was made much worse, in particular for someone who had different sets of duties.

118. Dr A said a physician in psychiatry has a duty to provide care and ensure the safety of patients as a primary duty. He said when Dr O'Flynn was as busy as he was, he was frequently left to respond to ongoing "crises" and/or emergencies and duties but that he also attempted to strike priorities.

119. Dr A stated that he had great personal and professional respect for Dr O'Flynn who, in his view, was a very good Clinical Director. He said Dr O'Flynn was always available to him and willing to help and that this assistance was also available to others including Dr Fisher. He said Dr O'Flynn made himself accessible at all times, often to the detriment of his own personal life.

Dr Roy

120. Dr Roy is a consultant psychiatrist with Hutt Hospital. Between 1987 and 1991 he worked at Timaru Hospital as a MOSS in psychiatry. He registered vocationally as a psychiatrist in June 1991 and became a consultant psychiatrist at Timaru Hospital. He started a private psychiatric practice in 1995. He became the Medical Adviser and the Director of Area Mental Health Services for Timaru in 1998 and continued in those roles through to the end of March 2000. He told the Tribunal that Timaru Hospital is smaller than

Invercargill Hospital (it served a total population of about half that of Southland at the relevant time) but provides a similar range of services. Between 2000 and 2002 he was the clinical head of the Department of Psychiatry at Hutt Hospital, Lower Hutt.

121. Dr Roy worked in the Inpatient Unit at Southland Hospital for one month in September 2000 after returning from overseas while awaiting his next position at Hutt Hospital.

122. Dr Roy said he had a reasonable amount of contact with Dr O'Flynn even though Dr O'Flynn worked mainly at CAFS and he (Dr Roy) was at the Inpatient Unit.

123. Dr Roy said that during his time at Southland Hospital he gained a very favourable impression of Dr O'Flynn's style as a Clinical Director which was gained not just from his own observations but from talking with the staff working in the Unit.

124. He said the nursing staff in particular found Dr O'Flynn very good to work with. He was always helpful and available to assess patients and do anything that needed to be done in the Unit. He would also attend at the Unit after hours, whether on call or not, and never made complaint.

<u>Dr Ryan</u>

125. Dr Cameron Ryan is a Registrar in Psychiatry employed by the Canterbury District Health Board.

126. From August 2001 until September 2002 Dr Ryan was employed by Southern Health as a Senior House Officer in the Inpatient Mental Health Unit at Southland Hospital (Ward 12).

127. Dr Ryan said that in the positions he had held he has had occasion to work with a number of consultant psychiatrists. In his experience, he said Dr O'Flynn's clinical competence was amongst the best he had experienced and that it was obvious to him that Dr O'Flynn was very busy keeping the psychiatric service in Southland going.

128. Dr Ryan stated that from his observations while Dr O'Flynn devoted a considerable amount of effort to the Child and Adolescent Psychiatric Service he still managed to see adult mental health patients and be the Clinical Director and the Area Director.

129. He said Dr O'Flynn was always prepared to see people in need at any time, in or out of hours. He described Dr O'Flynn as dedicated to ensuring that his patients were cared for as well as possible given the obvious absence of resources in Southland.

130. He said Dr O'Flynn set a standard, led them, and created the confidence which enabled them to keep going with efforts to build the Mental Health Service at Southland.

Dr Paul

131. Dr Gershu Paul is the current Chief Executive Officer of Southern Health. Prior to this he held, since May 2001, the position of General Manager of Hospital Services in May 2001. He had worked at Southern Health previously in various responsible positions between 1996 and 1998.

132. Dr Paul stated that the quality of services provided by Southern Health had improved significantly over the years, and not just since Mrs Burton's death. He said that improvements had been taking place for some years.

133. It was his belief that in the mental health area much of the credit for this had to be given to Dr O'Flynn who had worked tirelessly to provide a full mental health service to the people of Southland since taking up his employment there.

134. He confirmed that Southern Health's Mental Health Service is now both accredited and certified which was a long term project. He said this could not have been achieved in the time frame it was without Dr O'Flynn, who had also provided stability and consistency through taking up his position on a permanent basis.

135. Dr Paul told the Tribunal this had been independently recognised and, as an example, referred to Dr Barbara Disley, the Chair of the Mental Health Commission, who had

visited Southern Health's Mental Health Service in March 2001, during Mark Burton's time in Ward 12.

136. Dr Disley had written to the then Chief Executive Officer, Ms Bonner, enclosing notes she had taken of her meetings including with Ms Kitson and Dr O'Flynn. The Tribunal has seen these documents which confirm the effort and commitment made by Dr O'Flynn as Clinical Director (and others) who were striving to improve Southland's mental health service in all areas.

137. The Tribunal has already referred in a more general way to the work which Dr O'Flynn was doing and the gains achieved which resulted in accreditation and certification of the Southland Mental Health Service (prior to the laying of the present charge).

138. It is pertinent to set out here some of the elements of Dr O'Flynn's work which involved his meetings and interactions with others and which, he said, gave him a good clinical overview of the Service.

Doctors' meetings

139. On becoming Clinical Director, Dr O'Flynn held and led weekly meetings (every Thursday morning) with the medical staff of whom Dr Fisher was one. These meetings were described as the Doctors' Meetings.

140. There was some confusion as a result of some of the documentation produced as to whether these meetings were weekly or monthly. Dr O'Flynn, Dr Ryan, Mrs Areaitti, and Dr A, said these meetings were held every week. The Tribunal finds that they were.

141. Dr A said all available medical staff in the Mental Health Service would normally attend. This included Dr O'Flynn as Clinical Director, all of the Psychiatrists, Medical Officers Special Scale (MOSSs), Senior House Officers and/or Registrars. He said there was an expectation that the doctors attend these meetings.

142. Dr O'Flynn emphasised that while he encouraged attendance at these meetings, he never had to compel attendance. Such was the doctors' dedication that they attended "with

fairly religious adherence". He said where absences occurred they reflected people on leave or dealing with an acute case at the time of the meeting.

143. Dr O'Flynn said that the purpose of these meetings was peer group support and supervision where both clinical and service issues were discussed. Doctors presented a variety of issues and the meetings were generally a mutual debriefing session.

144. Dr A said that these meetings would generally alternate between a case presentation and a medical staff meeting. The case presentation would involve either a particularly interesting problem or one in which input of the department was sought in terms of treatment, management or care.

145. On the other occasions and also generally following on the case presentation there would be discussion relating to the ongoing operation of the department, any difficulties and how these might be handled and also any problems in terms of the numbers of staff available to do the work.

Weekly Review or Team Review

146. The weekly review or team review refers to the ward round in the in-patient unit at which both Dr O'Flynn and Dr Fisher attended.

147. These were multi-disciplinary meetings including psychiatrists, MOSSs, nurses, social workers, the needs assessor, pharmacists and the community workers.

148. The meetings involved a review of the patients in the hospital, their care and treatment planning.

The Medical Staff/Team Directorate Meetings

149. These meetings were held monthly. Dr O'Flynn attended as Clinical Director together with the senior medical staff.

150. Also in attendance were key members of the service such as the Team Leaders of the inpatient unit (Ward 12), the Invercargill Community Team, the Invercargill Children's Team, the Invercargill day centers, the Rhanna Clinic, the Gore Mental Health Team, the Queenstown Mental Health Team, the Southland Mental Health Emergency Team (SMHE Team), and representatives of the satellites as well as management.

151. These meetings included agenda items such as "Quality Improvement" and gave a very good overview of the service.

152. As an example, the minutes of the meetings of 1 and 29 March 2001 were produced, which recorded Dr O'Flynn and Dr Fisher in attendance. The minutes of 1 March record how Dr Fisher was to organise his time.

153. Dr O'Flynn said that while these meetings were monthly, there were often meetings in between. These included meetings with the SMHE Team as a group, individual supervision to team leaders of Rhanna Clinic on a weekly basis, and the Community Mental Health Team meetings by invitation.

Visits

154. There were regular visits by Dr O'Flynn to the Inpatient Unit as he generally had patients there himself.

Audit of files

155. There was regular audit of files for quality which was done routinely for all staff, including medical staff. This process was introduced by Dr O'Flynn and was operative before 2000. The (3 page) document which was produced by way of example was entitled "Patient Management Plan" and, although anonymised, was identifiable by numbers. As it transpired, it related to a patient of one of the MOSSs (not Dr Fisher). Dr O'Flynn believed that this process could reasonably be expected to bring to attention supposedly shoddy work.

Other Meetings

156. In addition to those already mentioned, other meetings included:

(a) Monthly Clinical Directors' meetings;

(b) The Mental Health Directorate meetings at which Dr O'Flynn attended with the Patient Services Manager (Ms Kitson);

(c) OCB Meetings (Ongoing Challenging Behaviour) at which Dr O'Flynn attended;

(d) There were also monthly incident report meetings where all incident reports were reviewed by Dr O'Flynn. Dr O'Flynn said when he became Clinical Director he encouraged and succeeded in changing the threshold of incident reporting. It was a conduit of information and could be used as a method of resolution. Dr O'Flynn said no incident forms were ever received about Dr Fisher.

(e) There were also almost daily patient service manager meetings often combined with other people with whom he did business, such as Human Resources personnel.

(f) Southern Behaviour and Support meetings.

Other Services

157. Despite staff shortages, Dr O'Flynn said that during his time as Clinical Director their service continued to fill gaps with the establishment of an Emergency Team, a Maori Mental Health Team, a Consumer Advisory Service and a Family Advisor.

Director Area Mental Health Service (Area Director)

158. In his role as Area Director for Southern Health mental health service, Dr O'Flynn also attended quarterly meetings of the Area Directors in Wellington, monthly meetings with the District Inspector (Mr Murdoch) in Southland, and monthly meetings with the SMHE Team as the main interface between the Area Director and the rest of the mental health service.

159. As Area Director, Dr O'Flynn said he would review daily the use of the Mental Health Act and all applications made under it; and almost daily would receive calls from conflicting parties whether someone should or should not be under the Mental Health Act. As Area Director, he had access to all legal procedures including the documentation of the Act.

160. Dr O'Flynn explained that his Area Director work gave him, as Clinical Director, the opportunity to have direct close observation on the critical points or the high risk points in the Service where clients could potentially fall through the cracks. He said it gave him, as Clinical Director, an observation point of the tenor of the Service on a day to day basis which is largely determined by the tenor of the medical staff leading the Service. In that way, he said he would have had an opportunity to review Dr Fisher's work and that of all the other medical officers, including his own.

161. In 17 years experience as a Clinical Director Dr O'Flynn said that having practised acute psychiatry for 20 years, one develops a sense of how the milieu is determined such as, for example, what might make staff defensive, sloppy, anxious or otherwise. He said that being the Area Director gave one a vantage point from which to assess and oversee a service.

162. Dr O'Flynn stated that the various meetings and interactions described above gave him an oversight of the Service, a general overview of how things were running, whether things were running smoothly or whether there were difficulties. He said it also gave him an opportunity to assess medical staff in a variety of roles to gather different perceptions from a multi-disciplinary perspective.

Role of Clinical Director

163. While there was debate whether Dr O'Flynn was aware of the content of his job description of Clinical Director, the Tribunal finds that he was.

164. The Tribunal accepts Dr O'Flynn's evidence that he knew only too well all the requirements of the positions he held. He said his duties were defined by the reality of the situation in the Southland Mental Health Service and not just by the several position descriptions which were "plagiarised".

165. Dr O'Flynn said it took the last six months of not carrying out the role to understand the depth and breadth of it. He was so committed to all his roles and tasks in order to deliver an effective Mental Health Service that he did not have time to stop and think about it.

166. The position description for Clinical Director was produced in evidence. It is worthy of note that while Dr O'Flynn took up his role of Clinical Director on 1 July 1998 he was not furnished with a position description until some fifteen months later when he initialled it on 4 October 1999.

167. Counsel for the Director of Proceedings drew attention in particular to two of the five *primary objectives* in the description, that is, *to ensure effective provision of clinical services*, and *to ensure training and development of medical staff as appropriate*; and under the heading of Quality, to *ensure all medical staff including Locums are properly credential* (sic).

168. The position description itself is much wider than those two aspects. Under "Primary Objectives" the Clinical Director was also required to manage the resources available to the Service which related to medical staffing, pharmaceuticals, diagnostic testing and imaging; to co-ordinate and liaise with other services as necessary; and to provide quality leadership. In addition, the Description referred to several bullet points under headings such as *financial, workforce, operational, leadership, quality, information exchange, customer focus,* and *capital and technical.*

169. Dr Patton at the time of giving evidence, was the Clinical Director, Mental Health Services of the Department of Health and Human Services based in Hobart, Tasmania. His qualifications are MB ChB Otago 1981 FRANZP 1989 (Specialist/Vocational registration as psychiatrist since 1989). Among the appointments he has held include that of Clinical Director in various organisations. Dr Patton was asked by the Health and Disability Commissioner in October 2001 to be the psychiatric expert adviser on a panel engaged as part of the Commissioner's inquiry into the Southland District Health Board – Mental Health Services, and the care that the Service provided to Mark Burton while an inpatient there in between 11 February and 30 March 2001.

170. The Tribunal notes and agrees with Dr Patton's fair concession that he (Dr Patton) did "not know of anyone whose week looks like their job description". He added "There are elements in the job description that are represented in most people's weekly activity but, you know, you can't necessarily map out a job description into blocks of time."

171. Dr Patton said that many people in senior medical positions were making "juggling judgments" all the time. The nature of what it is that gets "juggled" depends on the nature of the responsibility.

172. He agreed with Mr Rennie's hypothetical proposition that in a situation where a Clinical Director has to decide whether the most effective way of keeping an eye on staff is to do it one way or another, that is a judgment which may have to be made in terms of availability of time, the opportunity to interact with those persons at the same time the Director is available, and so forth.

173. Dr Patton also agreed with Mr Rennie's general proposition, on the evidence known to him in 2001, and reconfirmed at this hearing, that Dr O'Flynn was endeavouring to meet all his varied responsibilities, setting the appropriate priorities and, if necessary, working the extra hours or taking the extra patients to make the service function.

174. With regard to his own job description, when Clinical Head of Department at Hutt Hospital in 2000-2002, Dr Roy said it was not an accurate one. It was vague in that it recorded worthwhile objectives but that it was very difficult to "pin down" whether or not one was succeeding. Unlike Dr O'Flynn's, he said his own job description did not include purely management matters like the establishment of a budget but was much more clinically focused. He said the job description was "an evolving thing".

175. Dr Paul was asked by a member of the Tribunal how many tenths of a position was the role of the present Clinical Director. Dr Paul referred back to 1997/1998 when the whole entity of the organisation changed bringing in the concept of clinical governance. At that time, the job description of the Clinical Director was doubled, alluding to accounting and financial accountability under the philosophy of getting the Clinical Director and Management involved in combining themselves and taking ownership of financials,

operations and all activity. He said it was a challenge they were all working to try and achieve.

176. Notwithstanding this, Dr Paul said the whole Burton incident and what followed clearly highlighted that the job description for the Clinical Director [Dr O'Flynn] was not deliverable. In Dr Paul's words "There was no chance".

177. Since taking up his position as Chief Executive he had re-visited the job description, had considered what is realistic and achievable and, having done that, had allocated 3/10ths of a position which the current acting Clinical Director works on in that role.

178. Dr Paul meets with the current acting Clinical Director on a monthly basis and has given him administrative support so that he can carry out the role as best as possible.

Dr Fisher – Background and Employment with Southern Health

179. Against all of that background it is now appropriate to consider Dr O'Flynn's interactions with Dr Peter Fisher. It is those that are the subject of the charge.

180. That requires a consideration of Dr Fisher's role and background.

181. Dr Fisher was not called to give evidence. It was not readily apparent where he now resides although it would appear from the evidence that he has returned to live in the United Kingdom.

182. According to the records produced and the oral evidence of some of the witnesses, Dr Fisher attended the London Hospital Medical School between 1979 until 1984 when he graduated MB BS.

183. Between 1985 and 1990 he was employed by the Peterborough Health Authority during which time he was principally a Senior House Officer practising in various specialties including six months in family psychiatry and three months in general psychiatry at Peterborough District Hospital.

184. Between 1990 and 1992 he was employed by the Mersey Regional Health Authority in Liverpool including six months as a Senior House Officer in general psychiatry at Broad Green Hospital, six months as Senior House Officer in general psychiatry at Arrow Park Hospital and six months as a Registrar in family psychiatry and intellectual handicap at Arrow Park Hospital.

185. In December 1992 Dr Fisher was granted interim registration by the Medical Council of New Zealand and was approved for full registration here in March 1993. Under our Medical Practitioners Act 1995 he was deemed to hold general registration and was exempt from a requirement of general oversight for a period of five years until 1 July 2001.

186. Between 1992 and 1997 Dr Fisher was employed by Southland Crown Health Enterprise Limited (Southern Health) in the Department of Psychiatry at Southland Hospital, Invercargill as a Registrar in Psychiatry for two years and as a Medical Officer Special Scale (MOSS) in psychiatry for 2½ years. The Tribunal refers in more detail below to the role of the MOSS.

187. From 1997 until January 1999 Dr Fisher was employed by Coast Health Care Limited at Seaview Hospital Hokitika as a MOSS in psychiatry.

188. Between March 1999 and April 2000 Dr Fisher was employed by the Westland Medical Centre at Hokitika as a full time general practitioner on a salaried basis.

189. Between 19 May and 31 May 2000 Dr Fisher was employed by Southern Health providing Locum MOSS Psychiatry cover to Southland Hospital.

190. In October 2000 Dr Fisher was re-employed at Southland Hospital by Southern Crown Health Enterprise Limited (Southern Health) as a "MOSS Psychiatrist" and was employed in that position during the period when Mark Burton was admitted and discharged from Southland Hospital. Dr Fisher was considered to be a member of the senior medical staff.

191. While it is not clear from the evidence it seems that Dr Fisher left the employ of Southern Health around June 2002.

Legal Principles

Evidence and Submissions

192. While the Tribunal, in reaching its decision, has given full and careful consideration to all of the evidence presented to it together with the documents produced and the very helpful submissions of Counsel, for the sake of brevity it has not necessarily made reference to every aspect of them in this decision.

The Issue of Credibility

193. The Tribunal was impressed by the honesty and integrity of the witnesses. Where the Tribunal has rejected certain pieces of evidence or preferred the evidence of one or more witnesses over another, it is not to be taken as an adverse reflection on the witness or witnesses whose evidence has not been preferred. In some instances a witness might be adamant about an item of evidence yet have no recollection or a differing recollection about another item of evidence. In the Tribunal's view, this is a reflection that at the time of the hearing, the events under scrutiny were more than three years old and in some matters, older. In respect of one witness, there had been significant psychological problems. Further, the tragic death of the late Mrs Burton caused significant emotion and distress among members of staff and gave rise to multiple inquiries and hearings. Where there has been any uncertainty, the benefit of the doubt, as the law requires, has been given to Dr O'Flynn.

Onus of Proof

194. The onus of proof is on the Director of Proceedings who accepted at the outset that it is for her to produce the evidence which proves the facts upon which the charge is based and to establish that Dr O'Flynn is guilty of the charge, that is, professional misconduct.

Standard of Proof

195. As to the standard of proof, the Tribunal must be satisfied that the relevant facts are proved on the balance of probabilities. The standard of proof varies according to the gravity of the allegations and the level of the charge. If the charge against the practitioner is

grave then the elements of the charge must be proved to a standard commensurate with the gravity of what is alleged.

196. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand* (1984) 4 NZAR 369 in which the High Court adopted the following passage from the judgment in *Re Evatt: ex parte New South Wales Bar Association* (1967) 1 NSWLR 609:

> *"The onus of proof is upon the Association but is according to the civil onus. Hence proof in these proceedings of misconduct has only to be made upon a balance of probabilities; Rejfek v McElroy: [1966] ALR 270. Reference in the authorities to the clarity of the proof required where so serious a matter as the misconduct (as here alleged) of a member of the Bar is to be found, is an acknowledgement that the degree of satisfaction for which the civil standard of proof calls may vary according to the gravity of the fact to be proved".*

197. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand* [1989] 1 NZLR 139 at 163 in which it was emphasised that the civil standard of proof must be tempered "having regard to the gravity of the allegations". This point was also made by Greig J in *M v Medical Council of New Zealand (No.2)* (unreported HC Wellington M239/87 11 October 1990):

> *"The onus and standard of proof is upon the [respondent] but on the basis of a balance of probabilities, not the criminal standard, but measured by and reflecting the seriousness of the charge".*

In *Cullen v The Medical Council of New Zealand* (unreported HC Auckland 68/95, 20 March 1996) Blanchard J adopted the directions given by the legal assessor of the Medical Practitioners Disciplinary Committee on the standard required in medical disciplinary fora.

> *"The MPDC's legal assessor, Mr Gendall, correctly described it in the directions which he gave the Committee:*
>
> > *"[The] standard of proof is the balance of probabilities. As I have told you on many occasions, … where there is a serious charge of professional misconduct you have got to be sure. The degree of certainty or sureness in your mind is higher according to the seriousness of the*

> *charge, and I would venture to suggest it is not simply a case of finding a fact to be more probable than not, you have got to be sure in your own mind, satisfied that the evidence establishes the facts."*

Professional Misconduct

198. The starting point for defining professional misconduct is to be found in the judgment of Jefferies J in *Ongley v Medical Council of New Zealand* (above) when he posed the test in the following way:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? … 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, bearing in mind the position of the Tribunal which examined the conduct."*

199. In *Pillai v Messiter* [No.2] (1989) 16 NSWLR 197 the New South Wales Court of Appeal took a slightly different approach to judging professional misconduct from the test formulated in *Ongley*. The President of the Court considered the use of the word "*misconduct*" in the context of the phrase "*misconduct in a professional respect*". He stated that the test required more than mere negligence. At page 200 of the judgment Kirby P. stated:

> *"The statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. It includes a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."*

200. In *B v The Medical Council* (unreported HC Auckland, HC11/96, 8 July 1996) Elias J said in relation to a charge of "conduct unbecoming" that:

> *"… it needs to be recognised conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards".*

Her Honour then proceeded to state:

> *"That departure must be significant enough to attract a sanction for the purposes of protecting the public. Such protection is a basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that a finding of unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which is unfair to impose. The question is not whether the error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligation."*

Her Honour also stressed the role of the Tribunal and made the following invaluable observations:

> *"The inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates the usual professional practice while 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 usual practice, but patient interest 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."*

201. In *Staite v Psychologists Board* (1998) 18 FRNZ 18 Young J traversed recent decisions on the meaning of professional misconduct and concluded that the test articulated by Kirby P in *Pillai* was the appropriate test for New Zealand.

202. In referring to the legal assessor's directions to the Psychologists Board in the *Staite* case, Young J said at page 31:

> *"I do not think it was appropriate to suggest to the Board that it was open, in this case, to treat conduct falling below the standard of care that would reasonably be expected of the practitioner in the circumstances – that is in relation to the preparation of Family Court Reports as professional misconduct. In the first place I am inclined to the view that "professional negligence" for the purposes of Section 2 of the Psychologists Act should be construed in the Pillai v Messiter sense. But in any event, I do not believe that "professional negligence" in the sense of simple carelessness can be invoked by a disciplinary [body] in [these] circumstances …".*

203. In *Tan v Accident Rehabilitation Insurance Commission* (1999) NZAR 369 Gendall and Durie JJ considered the legal test for "professional misconduct" in a medical setting.

That case related to the doctor's inappropriate claims for ACC payments. Their Honours referred to *Ongley* and *B v Medical Council of New Zealand.* Reference was also made in that judgment to *Pillai v Messiter* and the judgment of Young J in *Staite v Psychologists Registration Board.*

204. In relation to the charge against Dr Tan the Court stated at page 378:

> *"If it should happen that claims are made inadvertently or by mistake or in error then, provided that such inadvertence is not reckless or in serious disregard of a practitioner's wider obligations, they will not comprise "professional misconduct". If however, claims for services are made in respect of services which have not been rendered, it may be a reasonable conclusion that such actions fell seriously short of the standard required of a competent and reasonable practitioner. This may be especially the case if such claims are regularly made so as to disclose a pattern of behaviour".*

205. In the Tribunal's view, the test as to what constitutes professional misconduct has changed since Jefferies J delivered his judgment in *Ongley*. In the Tribunal's opinion the following are the two crucial considerations when determining whether or not conduct constitutes professional misconduct:

(a) There needs to be an objective evaluation of the evidence and answer to the following question:

> Has the doctor so behaved in a professional capacity that the established acts and/or omissions under scrutiny would be reasonably regarded by the doctor's colleagues and representatives of the community as constituting professional misconduct?

(b) If the established conduct falls below the standard expected of a doctor, is the departure significant enough to attract a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards, and/or punishing the doctor?

206. The words *"representatives of the community"* in the first limb of the test are essential because today those who sit in judgment on doctors comprise three members of the medical profession, a lay representative and chairperson who must be a lawyer. The composition of the medical disciplinary body has altered since Jeffries J delivered his decision in *Ongley* in 1984. The new statutory body must assess a doctor's conduct against the expectations of the profession and society. Sight must never be lost of the fact that in part, the Tribunal's role is one of setting standards and that in some cases the community's expectations may require the Tribunal to be critical of the usual standards of the profession: *B v Medical Practitioners Disciplinary Tribunal* (above). In *Lake v The Medical Council of New Zealand* (unreported High Court Auckland 123/96, 23 January 1998, Smellie J) the learned Judge stated: *"If a practitioner's colleagues consider his conduct was reasonable the charge is unlikely to be made out. But a Disciplinary Tribunal and this Court retain in the public interest the responsibility of setting and maintaining reasonable standards. What is reasonable as Elias J said in B goes beyond usual practice to take into account patient interests and community expectations."*

207. This second limb to the test recognises the observations in *Pillai v Messiter, B v Medical Council, Staite v Psychologists Board* and *Tan v ARIC* that not all acts or omissions which constitute a failure to adhere to the standards expected of a doctor will in themselves constitute professional misconduct.

208. In the recent High Court case of *McKenzie v MPDT and Director of Proceedings* (unreported High Court Auckland, CIV 2002-404-153-02, 12 June 2003), Venning J endorsed the two question approach taken by this Tribunal when considering whether or not a doctor's acts/omissions constitute professional misconduct. He stated at para 71 of his judgment:

> *"[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 a 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."***

The Charge – Particular Two

209. The Tribunal has adopted Ms McDonald's approach, that is, it deals first with the second particular and then the first particular.

210. The Second Particular alleges:

> *Between 1 May 2000 and 30 March 2001 failed to adequately assess Dr Peter Fisher's experience and/or competence, and thereby determine the scope of his unsupervised practice to ensure that he met appropriate medical standards of care.*

211. The prosecution's case was that during the period commencing with Dr Fisher's appointment process in May 2000 through to Mark's discharge on 30 March 2001, Dr O'Flynn did not adequately assess Dr Fisher's experience or competence.

212. The specific matters relied upon by the prosecution are:

(a) Dr O'Flynn failed to satisfy himself as to Dr Fisher's level of skills or the nature of his experience at the time of appointing him as a MOSS.

(b) Dr O'Flynn should have obtained Dr Fisher's Human Resources file and, if he had done so, he would have immediately seen there were some issues of concern.

(c) Dr O'Flynn should have carried out reference checks himself or provided direction to someone else to do it.

(d) Dr O'Flynn should have spoken to medical staff, other than Dr Mackay, regarding Dr Fisher and also to his most recent employer in the psychiatric setting.

(e) Dr O'Flynn should have made adequate enquiries about Dr Fisher's failure on two occasions to complete training programmes.

(f) Dr O'Flynn should have made adequate enquiries about Dr Fisher's frequent changes of employment.

(g) Dr O'Flynn should have made adequate enquiries about Dr Fisher's "personality difficulties" or personality issues.

(h) Dr O'Flynn relied too heavily on the fact that Dr Fisher had been previously employed at Southland and failed to enquire of medical staff who had worked with him or supervised him during that period of employment.

(i) Dr O'Flynn chose to disregard concerns expressed by Nicki Kitson, the Patient Services Manager, and a Medical Superintendent at another hospital (name suppressed).

213. For Dr O'Flynn, Mr Rennie:

(a) Submitted the charge does not allege that Dr Fisher should not have been re-engaged, and nor does it allege that Dr Fisher lacked the experience and qualifications to be engaged;

(b) Emphasised that Dr Fisher was re-engaged to fill the same position to that which he had held at Southern Health in the period 1992 to 1997;

(c) Submitted Dr O'Flynn cannot be held accountable for the substantial failure of process which was evident in Dr Fisher's re-appointment, and that Dr O'Flynn was entitled to believe that the correct processes had been carried out;

(d) Pointed to the evidence of Professor Mellsop who stated that a failure to follow a post-appointment credentialling process could not be a breach of professional standards in 2000;

(e) Stated that the information available to Dr O'Flynn was that Dr Fisher had been employed by Southern Health for five years and there was no record of any kind to indicate any deficiency of qualification or skill which meant that he would not be re-engaged. He stated that Dr O'Flynn could not be expected to rely on gossip;

(f) Stated that no clinical or skills issue had been raised by any person when Dr Fisher was re-appointed and that his re-engagement was supported by medical and nursing staff who had previously worked with him;

(g) Referred to the evidence of Dr A that Dr Fisher had a plausible façade but was a man who had engaged successfully in duplicitous conduct over a long period;

214. Ms Tania Turfrey, the Registrar for the Medical Council of New Zealand, gave evidence that the term MOSS described a generally registered doctor working in a hospital but not part of a training programme and not employed as a specialist. The words "special scale" in the phrase "Medical Officer Special Scale" are a reference to the salary scale applicable to MOSS employees.

215. Ms Turfrey stated that the only Council-monitored requirement for a generally registered doctor was that he/she must work under the general oversight of a vocationally registered doctor practising in the same branch of medicine which includes participating in continuing medical education, audit and peer review, that is, keeping up with practice in the area in which the doctor is working. She stated this is a statutory requirement.

216. This is because the doctor is not vocationally registered and therefore cannot practise independently. Ms Turfrey used the phrase "not vocationally registered" to mean having no recognised post graduate qualification in a branch of medicine.

217. She explained that the requirement to "practise under general oversight" was separate from the day to day supervision that arises when a specialist leads a clinical team in a hospital.

218. Ms Turfrey stated, however, that under section 145(2) of the Medical Practitioners Act, the Medical Council of New Zealand determined that Dr Fisher was exempt from a requirement of general oversight for a period of five years, that is, until 1 July 2001.

219. There was further evidence as to the role of a MOSS from two witnesses called for the prosecution, namely, Professor Graham Mellsop and Dr David Patton and also others called on behalf of Dr O'Flynn.

220. Professor Mellsop is a professor of psychiatry and a fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP). He graduated as MD in 1972; and presently is professor and head of South Auckland Clinical School, Faculty of Medical and Health Services, University of Auckland. Among the appointments he has held include that of Clinical Director or similar in various organisations.

221. Professor Mellsop stated that the roles and skills of doctors employed as MOSSs are very wide and cannot be assumed. He stated that there were people in the role of MOSS who have minimal skills in psychiatry and those who are quite capable of functioning at virtually the same level as formally qualified psychiatrists. He stated that what duties to entrust to an individual MOSS has to be determined by the service and/or the clinical director for each individual case and the work supervised and monitored taking that into account.

222. Professor Mellsop's evidence was that if a Clinical Director did not personally undertake reference checks then that job should be delegated to a medically qualified person or alternatively specific guidance or direction should be given to any non-qualified person asked to make such enquiries.

223. Dr Patton told the Tribunal that MOSSs are a variety of types of doctor. Some are trainees in psychiatry who have chosen to opt out of the training programme for a period of time but who are likely to resume training to complete the specialist qualification and who wish to continue working in psychiatry in the meantime. Others may be former trainees in psychiatry who have not successfully achieved a specialist qualification and who are not pursuing further training but who wish to continue working in psychiatry without a specialist qualification. Others are doctors who may or may not have been trainees in psychiatry but who have some experience in working, sometimes of some considerable duration, in psychiatry (and perhaps even with a qualification in psychiatry but not required as having specialist equivalents).

224. By comparison Registrars are trainees in psychiatry who are formally enrolled with the College of Psychiatrists and who have specific training and supervisory requirements established by the College.

225. Dr Patton said he agreed with Professor Mellsop that there is an *enormous variety* of MOSSs who come to a position as a MOSS with a range of experience and qualifications behind them and, therefore, have quite different skills and abilities in carrying out that role.

226. Dr Patton stated that there are MOSSs who are able to, and do, act independently, in effect as psychiatrists; but, as Clinical Director, and as the person responsible for delegating clinical responsibilities on a ward or in another part of a service it is important to be confident that a person can act in the role assigned. He said that to reach that point of confidence it is important to assess that staff member's competence in relation to the care they are providing to their patients.

227. He stated that an important time to form a view as to an appointee's knowledge, skills and attitudes, was in the recruitment and appointment process.

228. He added, that it is at the stage of considering the person for employment the Clinical Director should know what the job is that he is expecting the person to undertake and should be matching that person's skills and experience to the requirements of the job.

229. It was Dr Patton's opinion that the degree to which a Clinical Director should make personal checks/follow-up referees in the appointment of a clinician to a service would depend upon a number of things including the nature of their involvement with the person previously. If a person had been previously employed by a service and the standard of practice was known to the Clinical Director or other senior clinical staff the main things to check with the other employer, depending upon the length of absence, would be:

(a) whether there had been any particular concerns during the intervening period;

(b) the nature of the work done; and

(c) what further training or other development may have taken place

230. Dr Patton stated that if Dr O'Flynn were less involved in appointment processes of other staff groups, because of constraints of time, or because there were other professional

leaders or advisers who would be expected to take a role in assessing clinical competence and suitability to a role then he may not therefore know that staff have been appointed without the skills and experience necessary for adequate conduct of their responsibilities. In the absence of direct involvement in the recruitment process, it was Dr Patton's view that Dr O'Flynn should have ensured that another clinically qualified practitioner was involved, and that he was appraised of and satisfied with the outcome of those reference checks.

231. Dr Patton said he would also expect the Clinical director to be closely involved with establishing roles and responsibilities for medical staff. This would include establishing or confirming suitability of job descriptions, reviewing applicants' skills against job requirements, direct clinical responsibilities and establishing support and review systems.

232. The existence of MOSSs and their use as "in effect psychiatrists" was an aspect of the New Zealand medical culture Dr O'Flynn said he had not previously experienced. He had had no experience of them prior to coming to New Zealand and, at the time Dr Fisher was employed at Southern Health, he had limited experience of them. However, the experience of them which he had had, was positive.

233. Dr O'Flynn said he had experience of three MOSSs, two of whom (Dr Mackay and Dr Rankin) worked for the Southland Mental Health Service and the other a paediatrician at Southern Health. All three were skilled doctors whom he held in high regard.

234. As has already been mentioned, prior to and subsequent to Dr Fisher's re-appointment in 2000, the Southland Mental Health Service was consistently and at times critically short of psychiatrists and medical officers as well as other staff.

235. As is apparent from the minutes of the Medical Staff/Team Directorate meetings, the issue of recruitment was a permanent item on the agenda.

236. Dr O'Flynn told the Tribunal that during the period 1998 to 2001 he regularly communicated with the Human Resources Department about recruitment of medical staff.

237. The person in particular with whom Dr O'Flynn dealt regarding recruitment was Ms X, a former member of staff.

238. An order has been made suppressing the publication of Ms X's name. It was agreed by counsel and accepted by the Tribunal that, for the purposes of publication, Ms X would be referred to as Ms X, a former member of staff.

239. There was conflicting evidence about Southern Health's recruitment policy and the responsibilities of Ms X.

240. Ms X confirmed that Dr Mackay, who had some 20 years experience as a MOSS in the Mental Health Service, strongly endorsed Dr Fisher's suitability for re-appointment in 2000.

241. Dr Mackay had worked with Dr Fisher during his previous period of employment (1992-1997) with Southern Health.

242. The minutes of the Medical Staff/Team Directorate meeting on 23 March 2000 record under the item "Recruitment Update" that *"Ms X* (meaning Ms X) *has contacted Dr Sue Harvey and Dr Peter Fisher and they are unavailable at present to help out"*. Ms X had no particular memory of doing that, but stated that if she had, the contact made would have been a telephone call. When asked whether at this meeting she recalled there being any controversy or debate as to whether Dr Fisher was a suitable person to return, Ms X replied that there were some people who were not too keen on him coming back but that the majority were happy for him to return.

243. Ms X said that during the time she was employed at Southern Health it was the usual practice for locums to be appointed through an agency which would provide the Human Resources section with the locum doctor's practising certificate and indemnity insurance papers and which would make the reference and referee checks.

244. Ms X said Dr Fisher's situation differed from the usual practice in that he approached Southern Health personally for the appointment.

245. She said that after speaking with Ms Kitson (Patient Services Manager) and Dr O'Flynn, she was directed by them to make arrangements for Dr Fisher to work as a locum in the Unit.

246. She said that she made one reference check for Dr Fisher which she thought was from a general practitioner on the West Coast and from memory no concerns were expressed about his practice. She could not recall specifically to whom she spoke at the time.

247. After a period of working as a locum Ms X said Dr Fisher approached the Mental Health Service requesting that he be given a full time position on a fixed term contract.

248. Her recollection was that Dr Fisher travelled to Invercargill on a Saturday for the purpose of meeting with Ms Kitson and Dr O'Flynn. She thought this was in May 2000. She said that they did meet with him following which she was invited to join the meeting. She said the purpose of her involvement was to identify what sort of employment contract Dr Fisher would be employed on, and to consider the Human Resources administration matters, such as whether he had a current annual practising certificate and indemnity insurance. She said that Dr Fisher left the meeting after a short period following which there was discussion between herself, Ms Kitson, and Dr O'Flynn.

249. According to Ms X, the Human Resources file which included Dr Fisher's curriculum vitae was available to them at that meeting.

250. Ms X said she was aware, having read the file and from her previous involvement in the Service, that there had been some issues with Dr Fisher during the period of his last employment at Southern Health. She referred to a dispute between him and Dr Binnie who was one of the child and adolescent psychiatrists at Southern Health at that earlier time. Dr Binnie had complained about Dr Fisher. She said the then Chief Executive Officer, Ms Anthea Green, had become involved in the dispute and she recalled there were concerns about Dr Fisher having refused to undertake on call duties and there appeared to be a personality clash with Dr Binnie.

251. Ms X said that for the purposes of this hearing she had looked at Dr Fisher's Human Resources file again. She said that there were now some documents missing from it. For example, she would have expected to see a document recording the reference check she undertook with the general practice on the West Coast and some other relevant documents including a letter from Dr Binnie and another from Dr Davis, a psychiatrist at Southland at the time. She said that the only letter on the file was one from Ms Green to Dr Fisher.

252. Ms X stated that Ms Kitson, Dr O'Flynn and she were therefore all aware what was on the file when they met to discuss Dr Fisher. She said that Ms Kitson seemed reluctant to employ Dr Fisher on a full time basis but Dr O'Flynn was keen to appoint him in view of the lack of staff.

253. At the conclusion of the meeting Ms X said it was agreed that she would recommend Dr Fisher's appointment on a fixed term contract to the Medical Advisers Committee.

254. She said that she made no further reference checks at the time and was not requested to do so either by Ms Kitson or Dr O'Flynn.

255. Ms X said that at the time there was a recruitment and selection policy in place and that appointments were usually made in accordance with it. In general she said the process involved the identification of a need for the requirement to fill a position by the Clinical Director in conjunction with senior management. Following advertisement, candidates were short-listed and interviewed by the Medical Appointments Committee which comprised the Clinical Director of the Service (who would be the Chairperson of that Committee), a medical adviser, a senior manager, a representative from an approved College or Society, and Ms X [**suppressed**].

256. She said it was usual and in accordance with the policy that she would seek written references for medical appointments which would be presented to the Medical Appointments Committee. She stated she did not have any medical qualifications or clinical experience herself.

257. Ms X added that Clinical Directors often took a lead role in the reference checking of medical appointments. She said it depended on the Clinical Director. The more experienced ones tended to know the candidates or knew people who had worked with them or trained them and there seemed to be a "network" that was tapped into by them.

258. In her experience, Ms X said that with the other Clinical Directors at Southern Health they would generally have spoken to referees put forward by the proposed candidate and would also have discussed that candidate's performance with colleagues.

259. She said Dr O'Flynn tended to rely on Human Resources to do the reference checks. She was aware that Dr O'Flynn was primarily focused on the need to appoint psychiatrists and in those circumstances they did not place priority on engaging in the reference checking process.

260. Following interview and consideration of referees, she said a candidate would be selected (by the Medical Appointments Committee) and recommended to the Medical Advisers Committee for appointment. The Medical Advisers Committee consisted of three Clinical Directors (which did not include Dr O'Flynn) and the Chief Executive Officer who at that time of Dr Fisher's appointment was Ms Mary Bonner.

261. Ms X said that following the meeting in May 2000 she took a recommendation for appointment of Dr Fisher to the Medical Advisers Committee which comprised the Chief Executive Officer, the Director of Nursing Staff, an Orthopaedic Surgeon, a Paediatrician, a Dental Surgeon and the Business Manager Surgical Services. Dr O'Flynn was not part of the Medical Advisers Committee which discussed the matter.

262. Ms X attended the meeting of the Medical Advisers Committee and recalled some concern raised by one of the other Clinical Directors (whom she did not identify) at the appointment of Dr Fisher in view of that person's previous knowledge of Dr Fisher's experience on the inpatient unit. However he did not detail what his concerns were but did refer to the previous period of employment.

263. She said these concerns were weighed against the fact that the Unit was short of medical staff and also that another MOSS in the Unit, Dr Mackay, was strongly endorsing Dr Fisher's appointment.

264. The Medical Advisers Committee approved the appointment and it was agreed on the expectation that Ms Kitson and Dr O'Flynn would manage any personality difficulties if they arose.

265. Ms X said she was not sure how that expectation was to be communicated to Ms Kitson and Dr O'Flynn but she thought it was by way of a letter or memorandum from the Chief Executive Officer. However, no such document was produced at the hearing.

266. Ms X concluded that the process of Dr Fisher's appointment was not done in accordance with the usual procedure or policy and that it was her first experience with a practitioner who had been previously employed by the Service and was seeking to return.

267. With regard to Dr Fisher's appointment as a locum in May 2000 (prior to his re-appointment in October 2000), Dr O'Flynn said that he was not involved in this appointment, although Ms X stated that Dr O'Flynn met with Dr Fisher on a Saturday in May prior to his appointment as a locum.

268. Dr O'Flynn did recall meeting with Dr Fisher at length on a Saturday. He believed the Saturday meeting was prior to Dr Fisher's return to permanent employment (in October 2000) rather than as a locum. He did recall a meeting on a Saturday with Ms Kitson and Ms X at some point discussing some of the issues surrounding Dr Fisher's return. He also recalled Dr Fisher being present in a room with all of them. However, he could not say whether this meeting with all of them present was on a Saturday.

269. Dr O'Flynn's diary did record an appointment to meet with Dr Fisher on Friday, 13 October 2000 but he could not be certain now to what this related.

270. With regard to the meeting at which all of them attended, neither Ms X nor Dr O'Flynn kept notes of it.

271. The Tribunal observes from the documents presented to it that on 17 May 2000 Ms X wrote to Dr Fisher thanking him for agreeing to provide "Locum MOSS Psychiatry cover to Southland Hospital from 19 May until 31 May".

272. There were four Saturdays in May, namely, 6th, 13th, 20th and 27th.

273. It is apparent from the evidence that Dr Fisher was not interviewed in person prior to arriving at Southland Hospital to take up his locum position on 19 May which concluded on 31 May and that he had already made arrangements to return to the United Kingdom prior to taking up the locum role.

274. Ms X's evidence-in-chief was that *"after a period of working as a locum Peter Fisher approached the Mental Health Service requesting that he be given a full time position on a fixed term contract"*.

275. According to this evidence of Ms X it was *after* he had finished working as a locum that he approached Southern Health for permanent employment and "came down to Invercargill" for an interview which would imply that he was at that stage living elsewhere.

276. In this regard the Tribunal refers also to the evidence of Mr Y (name suppressed).

277. Mr Y stated that around Easter 2000, as Ms Kitson was taking some leave, he was asked to step into her role [for a few days]. He had apparently filled in for her on previous occasions.

278. While in that role he was informed that there was a gap in the roster for senior medical cover and a psychiatrist was needed. At this time there was difficulty in recruiting doctors and he said it was not uncommon to have locums brought down from Christchurch or Dunedin.

279. Dr O'Flynn said that he was only involved in the engagement of Dr Fisher as a locum to the extent that he had told the Mental Health Counsellor that he needed to have a weekend off as he was continuously on call and was unable to fulfil family commitments.

280. Mr Y telephoned Ms X [**suppressed]**. He told her that there was an impending shortage of senior medical cover. He said she told him she was aware of the impending shortage and was having great difficulty finding anybody apart from a doctor working on the West Coast.

281. Mr Y said he had a vague recollection that Ms X implied that the particular doctor (who turned out to be Dr Fisher) presented some difficulties for Ms Kitson but she did not tell him why that was and he could not be sure after so many years whether it was Ms X who implied that Dr Fisher presented Ms Kitson with some difficulties, or whether it was Ms Kitson's personal assistant who had the reservations. From his recollection he took Ms X's comment to mean that there was some issue about whether the particular doctor got on with other people and he assumed this to be in the area of personality or remuneration/employment conditions.

282. Mr Y said he informed Ms X that they needed to fill the gap in the roster and asked her to hire the doctor as a locum. He assumed that Ms X would take care of the arrangements for employing the doctor, which she did. He said it was Ms X's area of expertise, that she was very experienced in the hiring of senior medical staff, and so the task of negotiating with the doctor was left to her.

283. He did not have any contact with any person other than Ms X in relation to the arrangements to hire the particular doctor. It was Ms X who knew of Dr Fisher's availability but he did not know how she knew that.

284. Ms X said she had no recollection of her conversation with Mr Y.

285. When Ms Kitson returned Mr Y remembered passing a remark to her about the employment of Dr Fisher. He believed Ms Kitson was satisfied that the matter had been dealt with to ensure that there was a doctor on duty as required to run the Service.

286. Mr Y said he was not aware of any clinical concerns about Dr Fisher when he was employed as a locum in May 2000 or at the time of re-appointment in October 2000 (at which later time Mr Y was[employed in the service]) until after Mrs Burton's death.

287. He said he did not see Dr Fisher's personnel information, would not normally have done so, did not know there was a file in relation to prior employment, and would have been surprised if any of it had been given to him.

288. Mr Y said that due to Ms X's considerable experience [in the role], he believed it to be her role to co-ordinate the review of any personnel information, the doctor's qualifications, registration, residency status, and so forth, and to consider the appropriateness of the doctor to fill the position. If she had any issues, then he would have expected her to refer such issues to the Clinical Director and other senior management on their return. He was not asked to carry out any tasks related to Dr Fisher's employment.

289. When asked in cross-examination whether he had ever been actively involved in recruiting, undertaking reference checks, or liaising with the Clinical Director or senior medical staff about the appointment of a medical staff member, Mr Y said he would contact the Human Resources Department if he were aware of somebody's availability such as a psychiatrist and leave it to them. He did not have intimate knowledge of Ms X's role on a day-to-day basis or stage-by-stage basis in the process of appointing someone.

290. The Tribunal accepts Mr Y's evidence and where it conflicts with Ms X's evidence prefers Mr Y's.

291. The Tribunal also prefers the evidence of Dr O'Flynn in this regard where it conflicts with Ms X's.

292. It is most improbable on the evidence that Dr O'Flynn met with Dr Fisher in May 2000, as asserted by Ms X. She has referred to this meeting involving Ms Kitson as well.

293. While Ms Kitson has not been called to give evidence, it is apparent that she was on leave around this period of time because Mr Y was filling in for her. Dr O'Flynn needed some time off in the weekend so he was not on call. Further, the letter of 17 May 2000 from Ms X to Dr Fisher implies that there was no meeting in the first part of May and according to her own evidence the meeting when he "came down to Invercargill" occurred after his locum period had expired on 31 May 2000.

294. The Tribunal finds that Dr O'Flynn was not involved in Dr Fisher's appointment as a locum other than being aware that he was available to do some locum work and had been previously employed in undertaking similar work at Southern Health. Essentially, the recruitment and appointment of Dr Fisher as a locum was undertaken by Ms X after discussion with Mr Y.

295. The Tribunal accepts Dr O'Flynn's evidence that when Dr Fisher was at Southern Health for two weeks as a locum, Dr O'Flynn did have some interaction with him although on a fairly superficial level and also had some discussions in more detail with Dr Fisher (but did not have a formal meeting of the type which Ms X suggested he had with her and Ms Kitson present on a Saturday in May) and that after those discussions he was "very comfortable" about Dr Fisher coming to work with them.

296. On 5 July 2000 Ms X wrote to Dr Fisher in the United Kingdom confirming that Southern Health was offering him the position of MOSS Psychiatrist in the Mental Health Unit commencing in October 2000 for a period of three years. She enclosed with her letter an individual employment contract and other information relating to his remuneration package. Ms X concluded her letter by congratulating Dr Fisher on his appointment and looking forward to his response and welcoming him back to Invercargill.

297. With regard to the employment contract, Dr Fisher is referred frequently throughout it as a "MOSS Psychiatrist". A clause entitled "Clinical Supervision" appears in his employment contract, but deals with his supervision of other staff, not supervision of him.

298. With reference to the term "MOSS Psychiatrist", it was Ms X's understanding that MOSSs in Southland Hospital had primarily the same role as a consultant. She said that this description would have been contained in the contracts for other MOSSs at Southern Health, for example, "MOSS Paediatrician".

299. Ms X confirmed that there was a vacancy for essentially the same position that Dr Fisher had held before he left in 1997. She confirmed that she had been trying to fill the vacancy for several months and that in February 2000 Dr O'Flynn had to cover the work as there was no specific psychiatrist for the inpatient unit. There was only Dr Rankin who was a

MOSS. Ms X confirmed it was her understanding that essentially Dr Fisher was returning to undertake the role that he had held previously before he left in 1997.

300. Ms X also confirmed that once Dr Fisher had accepted her offer of 5 July 2000 it was generally known that Dr Fisher was returning to the inpatient unit.

301. With regard to Dr Fisher's Human Resources file (or personnel file or personal file – all these terms were used interchangeably during the evidence), Ms X stated it was available at the meeting which she thought had taken place in May (but which the Tribunal has found did not).

302. Mr Rennie put to Ms X that Dr O'Flynn was firm in his recollection that he did not see the Human Resources file in the sense of being able to read it and look through it until much later after Dr Fisher had arrived to take up his permanent appointment. Asked if that could be correct, Ms X agreed. (The Tribunal returns to this later.)

303. A document entitled "Recruitment and Selection Policy" was issued by Southern Health on 4 September 2000, although the schedules (apparently attached to it) are shown as being issued on 2 August 2000.

304. A further document entitled "Recruitment Selection And Orientation Procedures" was issued by Southern Health on 19 August 1993 with a review date of 19 August 1994 as part of its Human Resources Policies Manual.

305. It was put to Ms X by Mr Rennie that the policy which was issued on 4 September 2000 could not have applied because it was issued *after* Dr Fisher was offered employment in July 2000. Ms X agreed.

306. In particular, Ms X was referred to page 10 of the 1993 policy under the heading "References and Other Resources". It provides that *"References are sought by the manager about the applicant's previous experience, qualifications, personal attributes or skills to verify the applicants suitability for the position"*.

307. At page 11, under the heading "Applicants previously employed by Southern Health" is recorded: *"If applicants have previously been employed by Southern Health, managers should consult with the previous manager if available, or Human Resources to determine if there is any valid reason why they should not be re-employed, prior to making an appointment decision"*.

308. This indicates a different and lesser process of enquiry if the applicant had been previously employed.

309. Ms X agreed that for this process of enquiry to be undertaken she and/or Ms Kitson would not have been able to go to the previous manager as he had left, so they would need to look through Dr Fisher's personal file and/or obtain local knowledge.

310. Ms X also agreed that some of the required tasks were partially cleared away because not only had Dr Fisher been previously employed but he had returned as a locum for two weeks in May 2000 and was known to be acceptable to the medical staff team.

311. Ms X also confirmed there was nothing on the formal record of Southern Health which Ms X knew about that indicated Dr Fisher should not be re-employed.

312. Ms X was asked in re-examination whether there were any other policies between 1994 and September 2000. Ms X said that there were *"draft policies floating around"* and that there were *"several drafts"* prior to the one issued in September 2000. She was not able to say which policy was operating in May 2000 although her recollection was that it was a "*version"* of the 2003 one – *"similar to that"*.

313. The only policy which has been produced as being in existence at the time of Dr Fisher's re-appointment was the 1993 one. In view of the state of the evidence it would be unsafe to rely on any other policy, and the Tribunal cannot rely on one which was only in existence after Dr Fisher's re-appointment.

314. However, what can be gleaned from the evidence is that there was significant involvement of Human Resources staff [there was also significant involvement of], Ms X in the recruitment and appointment of senior medical staff.

315. In this regard we refer to the evidence of the Mental Health Counsellor (above), Dr A, Dr Paul and Dr O'Flynn.

316. Dr A has been employed by Southern Health as a consultant psychiatrist since xx. He has practised in xx and had experience with the recruitment of doctors. He said he had been actively involved in recruiting in the past. In his experience a doctor who had previously been satisfactorily employed in a service, particularly a doctor who had ongoing professional work experience in psychiatry, would be welcome and likely to be offered a position if one were available. He added that as an absolute and essential matter of procedure, the doctors' credentials and good standing would be re-verified by Human Resources and references would be sought in writing to confirm up-to-date performance.

317. With regard to Ms X, Dr A said he had had personal pleasant experiences of working with her and also a number of problems. He said that there were occasions when things that she said she had done had not been done. He understood that management valued her services highly for a time although his view was not as generous and he noted that he found it necessary to go to her xx supervisor in order to have contractual obligations carried out.

318. Ms X said she was *"absolutely certain"* nothing like that happened.

319. Dr A told the Tribunal he was aware that he was not the only senior medical staff member in Psychiatric Services to have had such difficulties with Ms X.

320. Dr A had not seen his own personnel file. However, he was aware from his own personal referees that they were contacted in writing by Ms X and told him that they had provided her with written references. He said that when he looked at Dr Fisher's personnel file, he was struck by the absence of any written letters to or from any of Dr Fisher's referees who were not even identified. He said he was and continues to be amazed and unable to understand how such a situation could prevail.

321. What this confirms is that it was part of Ms X's duties to contact the referees and obtain from them written references.

322. The Tribunal accepts the evidence of Dr A and where it conflicts with Ms X's evidence prefers Dr A's.

323. Dr Paul stated that he was appointed as the General Manager of Hospital Services in May 2001. It was immediately apparent to him that there were serious deficiencies in the recruitment process for senior medical staff at Southern Health. As General Manager, he held overall responsibility for the Human Resources team.

324. He stated he was not comfortable with the degree of responsibility Ms X had. Her role, as outlined in her position description, was to provide support to the Human Resources Manager and relevant Clinical Director during the recruitment process. He said Ms X was not simply providing support but rather was making offers and recruiting to positions directly without any adequate involvement of the Human Resources Manager or the Clinical Director.

325. He said she had signed contracts, under her delegated authority, which he considered should have been signed off at a higher level by the Human Resources Manager, the relevant Unit Manager, the General Manager or Chief Executive Officer.

326. Dr Paul said they had shortages of staff in virtually all areas of the hospital service, variable quality in the staff recruited and some disenchantment in the staff employed. In his judgment this was substantially due to the Human Resources problems.

327. Some time in June 2001, he said he called Ms X and raised with her his concerns about her implementation of the recruitment process. Ms X denied this had occurred. Dr Paul said he advised her that he was not prepared to countenance a continuation of a potential risk to the organisation posed by her failure to follow process in the recruitment of staff and locums. He asked her to take directly to him any recruitment offers before they were signed off. Ms X accepted this happened. Dr Paul said Ms X responded that she would

take to him offers and retention issues. He wanted to take on a greater role in the recruitment and retention of staff.

328. Dr Paul explained that soon after this discussion with Ms X he was told by the then Chief Executive to stay away from Ms X. He did not know why but later learned that the Chief Executive had written a letter to Ms X in which she required an explanation for a confession by Ms X that she had misled the Chief Executive.

329. Dr Paul said he expressed his concern at the time to the Chief Executive about permitting the current state of affairs to continue because he was accountable, there were significant errors and problems, and he wanted the proper instructions to be followed.

330. Dr Paul gave other evidence which reflected adversely on his belief in Ms X's credibility and her level of competence.

331. He said that he continued to seek Ms X's compliance with management processes but there continued to be a number of issues of non-performance, provision of incorrect information, and failure to carry through recruitment of staff. Some four months later Ms X handed in her notice of resignation and subsequently left the Service on xx.

332. The Tribunal accepts Dr Paul's evidence and where it conflicts with Ms X's evidence, prefers Dr Paul's.

333. Ms X was cross-examined at some length about whether she had made contact with Dr Fisher's previous employer, Westland Health Centre. She was certain that she had telephoned someone and asked some basic information but she could not remember who that person was and she had not made a note of it.

334. In this regard, an affidavit of Anna Dyzel, a vocationally registered general practitioner working in Hokitika at the Westland Medical Centre, was presented (by consent) on behalf of Dr O'Flynn. Dr Dyzel is the senior partner at the Centre. Dr Dyzel confirmed that Dr Fisher was employed at the Westland Medical Centre from 8 March 1999 to 20 April 2000 as a full time general practitioner. She had met Dr Fisher when he was

working as a MOSS at Seaview Hospital in Hokitika and within the community mental health team. Both she and Dr Fisher often had responsibility for the same patients (although different aspects of their care) and as a result of that they developed a working relationship. Dr Dyzel also provided medical cover at Seaview and through that came to know Dr Fisher.

335. She stated that Dr Fisher finished working at the Westland Medical Centre on 20 April 2000 as he had found a position in psychiatry. She was sad to see him leave as he had been a very good employee and she would have had no hesitation in extending his contract if he had wanted to stay.

336. She could not recall whether he had told her where his psychiatry position was but she recalled that he returned to the United Kingdom for a holiday as soon as he left the Westland Medical Centre. She was not aware he had moved to Invercargill until the publicity about the Burton case arose.

337. With regard to the suggestion that Ms X had contacted the Westland Medical Centre for a reference check on Dr Fisher, Dr Dyzel stated that she did not receive any such enquiry and nor, to her knowledge, did anyone else at the Medical Centre provide any reference.

338. Following a call from the Health & Disability Commissioner in October 2003 as to whether she had ever been approached by Southern Health for a reference check and whether she had any concerns about Dr Fisher's practice at the Westland Medical Centre, Dr Dyzel checked with the receptionists and nurses at the Centre to see if they could locate any evidence of such a request but could find no such evidence. She said she was the only permanent general practitioner and the senior partner there and the only person who could provide such a reference.

339. Dr Dyzel said that she had reflected on what reference she would have given had she been requested to do so. She would not have given an adverse one concerning Dr Fisher.

340. The Tribunal accepts the evidence of Dr Dyzel (which was not challenged) and where it conflicts with Ms X's evidence prefers Dr Dyzel's.

341. The Tribunal is not satisfied that Ms X made any reference check from the Westland Medical Centre concerning Dr Fisher, despite a responsibility to do so imposed by Southern Health's policy and practice.

342. As to Dr O'Flynn's knowledge of Dr Fisher, it is appropriate to comment that when Dr O'Flynn joined Southern Health in 1998 Dr Fisher had left Southland after having been employed there between 1992 and 1997.

343. As already stated Dr Fisher was re-employed in a locum position for two weeks from 19 to 31 May 2000. Dr O'Flynn said he was not involved in his appointment as a locum (which the Tribunal accepts). Dr O'Flynn was aware that Dr Fisher's appointment as a locum was strongly endorsed by Dr Mackay (whom Dr O'Flynn held in high regard), a MOSS with some 20 years experience who had worked with Dr Fisher during his earlier period of employment. Dr Mackay was a member of the senior medical staff of the Mental Health Service.

344. Dr Fisher was re-employed as a MOSS from October 2000. Dr O'Flynn said this was processed by Human Resources and was not done on his initiative. He accepted that he knew the appointment was in process, that he supported it and that to a limited extent it was discussed with him. That was on the basis of his knowledge at the time.

345. As time went on, Dr O'Flynn said he knew more about Dr Fisher. There were many points about which he was able to sit and chat with him as they both worked together in a small unit.

346. At some point in time he saw a curriculum vitae for Dr Fisher but he could not recall for certain when this was.

347. He did recall that in October 2001 he requested Ms X to provide him with a copy of the curriculum vitae following which she forwarded to him a three page document. Dr O'Flynn thought this was when he first saw it but was not certain.

348. Dr O'Flynn stated however that he did have knowledge of Dr Fisher who had told Dr O'Flynn of the places where he had worked. Dr O'Flynn said he had a particular interest because they had certain coincidences. One was that Dr Fisher had trained at London Hospital in Whitechapel, London, at around the time Dr O'Flynn was lecturing there. Although neither had any memory of the other, Dr O'Flynn knew the medical school and many people with whom Dr Fisher had trained; another was that they had both undertaken some training at the same Institute of Family Therapy in London.

349. Dr O'Flynn's knowledge arose from conversations he had had with Dr Fisher. Dr O'Flynn said he was not able to say now, three years later and after significant personal trauma, precisely when and how these discussions took place and whether they would be categorised as formal or informal. He said what he was left with were the "high points" and the unusual things that "stick in one's mind".

350. Dr O'Flynn said he did talk about matters at length with Dr Fisher and met with him on a regular basis while he was employed at Southern Health.

351. While Dr O'Flynn may not have seen Dr Fisher's curriculum vitae at an earlier time, the Tribunal is satisfied and finds on the evidence as a whole that Dr O'Flynn did have discussions with Dr Fisher and was aware from those conversations of Dr Fisher's qualifications, training and experience at an early stage.

352. The Tribunal turns to the assertion that Dr O'Flynn should have obtained Dr Fisher's Human Resources file and that, if he did, he would have immediately seen there were some issues of concern.

353. Dr O'Flynn said that he did not see Dr Fisher's personnel file at the time Dr Fisher was offered re-appointment to Southern Health.

354. He did not believe it was available to him at the time of Dr Fisher's appointment but even if it had been he thought it would not have contained clinical information and that it could not be easily accessed and certainly not without the full knowledge and consent of the owner

of the file. He added that such a file is generally not used within medical circles as an important working document.

355. It was readily apparent during the hearing of this charge that there was no complete Human Resources/personal/personnel file relating to Dr Fisher. This comment is not to be construed as any adverse criticism of the prosecution counsel who were most professional at all times. Despite their own requests at an early stage for a copy of Dr Fisher's file, it seems that it was not provided as a complete entity but emerged in bits at different stages from different sources.

356. Some correspondence/memoranda was produced at the hearing which Dr O'Flynn had never seen before. Some correspondence had been made available during preparation for the hearing of the charge. The sources of it were not precisely ascertained although some was said to have come from the Ministry of Health. No-one was sure how the Ministry came to have such documents. The other source was Southern Health but Dr Fisher's actual file at Southern Health was not, it seems, in one place or one piece.

357. Ms Turfrey, the Registrar of the Medical Council of New Zealand, confirmed that prior to Mrs Burton's death on 31 March 2001, the Council's file on Dr Fisher did not contain any adverse comment about him.

358. Dr O'Flynn said that although after Mrs Burton's death there was no shortage of Dr Fisher's detractors coming forward regarding his competence, nobody brought that information to his attention at an earlier time and nor did they bring it to the attention of the Medical Council or the College of Psychiatrists.

359. In this regard, the Tribunal refers also to the evidence of Dr A.

360. In October 2001 Dr A undertook intensive and remedial supervision of Dr Fisher (referred to later).

361. Under the contract of supervision the employer undertook to provide Dr A with a copy of Dr Fisher's personnel file from the Human Resources Manager. He said he sought and received a file in January 2002.

362. Dr A said he was given to understand that Ms X had recently received a copy of Dr Fisher's personnel file supplied by Southern Health for the purposes of this hearing and that she had suggested that certain documents she recalled being on the file when she was employed there were no longer on the file. Dr A referred to the two letters in particular to which Ms X had referred in her evidence. However, Dr A said when he looked at the file in January 2002 one of the letters was not on the file and he did not know of the other.

363. The Tribunal observes that of the documents produced at the hearing, the first Dr A had seen them was the previous evening when shown them by defence counsel, bar one. The one that he had seen (when he called for the file in January 2002) was from Ms Anthea Green a former Chief Executive of Southern Health, to Dr Fisher. It did not refer to clinical matters.

364. It is also worthy of note that Ms McDonald handed Dr A during his cross-examination a file in three volumes which she identified as a copy of Dr Fisher's Human Resources file which she had obtained under subpoena. Dr A looked through the file which he said predominantly related to financial and contractual information but did relate to the time period in question. He said he had not seen it before that day nor had he seen the documents on it.

365. With regard to the personnel file of Dr Fisher, where there is any conflict of evidence between Ms X and Dr O'Flynn and Dr A, the Tribunal prefers the evidence of Drs O'Flynn and Dr A.

366. Having carefully analysed the evidence, the Tribunal finds that the evidence does not establish to any satisfactory standard precisely what documents were on Dr Fisher's Human Resources/personal/personnel file prior to Mrs Burton's death. It would be unsafe for the Tribunal to conclude that had Dr O'Flynn seen it or called for it at an earlier time it would have contained documents which would have caused alarm bells to ring.

367. Further, Ms X conceded in cross-examination that there was nothing on the formal record of Southern Health which she knew about that indicated Dr Fisher should not be re-employed.

368. Even if there were then the Tribunal finds that in accordance with the practice and policy of Southern Health at that time it was the responsibility of Ms X or the Human Resources Manager to have made Dr O'Flynn aware of it.

369. The Tribunal does not accept that, in the particular circumstances, there can be any valid criticism of Dr O'Flynn for failing to obtain Dr Fisher's Human Resources file.

370. The Tribunal refers to the assertion that Dr O'Flynn should have made adequate enquiries about Dr Fisher's frequent changes of employment.

371. The Tribunal is satisfied on the evidence that the changes of Dr Fisher's employment were not unduly frequent; and that such changes are not necessarily uncommon.

372. As Mr Rennie pointed out, if one examined the curriculum vitae of Dr A (whose repute was not in doubt) one would see that he too had made a number of changes to his employment.

373. The Tribunal does not accept that any failure on Dr O'Flynn's part regarding such an enquiry should invite any criticism in the circumstances.

374. The Tribunal refers to the assertion that Dr O'Flynn chose to disregard concerns expressed by Ms Kitson, the Patient Services Manager, and a Medical Superintendent at another hospital (name suppressed – to be referred to as "a medical Superintendent at another hospital").

375. Neither gave evidence before the Tribunal but the evidence does not suggest that either of them had concerns about Dr Fisher's clinical competence or, if they had, neither of them expressed those concerns to Dr O'Flynn.

376. With regard to Ms Kitson, the Mental Health Counsellor (whose evidence the Tribunal accepts) said that he understood from Ms X (when Dr Fisher was appointed as a locum in May 2000) that the only issue was whether Dr Fisher got on with other people which he assumed related to personality or remuneration/employment conditions.

377. When Ms Kitson returned from leave, the Mental Health Counsellor said he spoke to her about the employment of Dr Fisher (as a locum) and she was satisfied the matter had been dealt with appropriately. She did not pass on to him any adverse comment about Dr Fisher.

378. Dr O'Flynn said that the only reservations which Ms Kitson expressed to him about Dr Fisher was that he had a difficult personality and issues or arguments he might have would be regarding administrative or employment matters. He was emphatic that Ms Kitson's concerns, as expressed to him, were not of a "clinical safety nature".

379. The Tribunal accepts Dr O'Flynn's evidence concerning Ms Kitson in this regard. It finds he did not disregard her concerns but rather attributed little weight to them as they did not relate to matters of a clinical nature. The Tribunal accepts that Dr O'Flynn's conduct in this regard was appropriate.

380. With regard to a Medical Superintendent at another hospital, Dr O'Flynn said a Medical Superintendent at another hospital approached him at an Area Directors' meeting and spoke briefly about Dr Fisher. He said words to the effect that he had heard Dr Fisher was joining the service at Southland and commented that he was an "empire builder" which Dr O'Flynn should watch out for. Dr O'Flynn said a Medical Superintendent at another hospital did not offer any other information and made no mention at all that there were any issues relating to Dr Fisher's clinical skills.

381. Dr O'Flynn said that the reference to "empire building" was of no consequence as they had in their department a hierarchical structure, particularly among the medical staff, which an "empire builder" could not disrupt. He also considered it would have been both intrusive and inappropriate to have indulged in gossip about Dr Fisher at such a meeting and without Dr Fisher's consent.

382. In view of the limited observation made by a Medical Superintendent at another hospital (and which did not reflect on clinical practice), Dr O'Flynn did not consider there was any good reason why he should have taken the matter further with him.

383. The Tribunal agrees.

384. With regard to the criticism that Dr O'Flynn should have spoken to medical staff, other than Dr Mackay regarding Dr Fisher and also to his most recent employer in the psychiatric setting, the Tribunal has already found that this was the responsibility of the Human Resources Department. [It also found that it was the responsibility], in particular, of Ms X in accordance with Southern Health's practice and policy.

385. Also, Dr Mackay was a member of the senior medical staff in the Mental Health Unit with 20 years experience who had previously worked with Dr Fisher and who had strongly endorsed his re-engagement. Dr O'Flynn held Dr Mackay in high regard and had no reason to doubt her word.

386. Further, as Dr O'Flynn said (and which Dr Patton endorsed) it is not just medical people who can give opinions in such matters. Dr O'Flynn said he had a high level of trust in the experienced nursing staff of the service, many of whom spoke to him in favourable terms of Dr Fisher.

387. One of those persons who had spoken well of Dr Fisher was Mrs Marie Mawhinney, the Ward Manager at Southland Hospital during Dr Fisher's earlier period of employment there. A document subsequently obtained by Dr O'Flynn's counsel for the purposes of this hearing recorded that Mrs Mawhinney had spoken to a psychiatrist (Dr Anderson of Seaview Hospital at Hokitika) in 1997 when he had made enquiries of Dr Fisher (who had applied for a position there). Mrs Mawhinney, among other things, had said that Dr Fisher had "held the place together" for six months when there was no psychiatrist there. A further document was produced which confirmed Dr Mackay had told Dr Anderson that when at Southland Hospital in the earlier period, Dr Fisher had run the inpatient unit by himself for some time without problems and with only distant supervision from Dunedin. Dr O'Flynn said this was confirmed to him by Dr Mackay and a number of nursing staff.

388. With regard to recruitment, Dr Roy said that when he first became a psychiatrist (in 1991) if a doctor or psychiatrist was to be appointed to a psychiatric unit then he expected a Senior Appointments Committee to be convened to consider the appointment. One of the senior doctors would conduct the reference checks.

389. However, he said more recently as they have moved towards a more corporate hospital environment and structure, those reference checks have tended to be done more by the Human Resources Department in the hospital.

390. Around May 2000 in Timaru, Dr Roy said they were starting to move towards a more corporate environment. Clinical Directors were having less involvement in the hiring and firing of staff. Any recruitment issues were driven more by the Human Resources Department and there was a general trend towards a professional management team.

391. With regard to a doctor who had been previously employed within a hospital service, in his experience only a perfunctory reference check would be performed. He said staff usually have an impression or opinion about previous employees already and rely on that to decide if a person will be re-employed.

392. He said if, for example, they were employing a Registrar who had worked with them before he would go to the nurse in charge of the ward and ask what that person was like. He said they would tell you "within thirty seconds". He said he would want to speak with those who had worked with the person before which may or may not be a senior doctor.

393. Dr Roy said often it was the persons who had worked "under" the proposed employee who would give a more accurate account than those who had worked "over" them.

394. With regard to referees, he said the best of all was when someone in one's department had worked with the person which he described as being like "the gold standard".

395. He said there was nothing magical about the medical field – it was like any other situation.

396. The Tribunal accepts that Dr O'Flynn had made adequate enquiries regarding Dr Fisher's previous performance from Dr Mackay, nursing staff and others and is of the view that, in the circumstances, this was reasonable.

397. With regard to Dr Fisher's failure to complete his specialist qualification, Dr O'Flynn did not consider this was necessarily to his discredit.

398. He said Dr Fisher had told him he had been in the training programme in England (he understood in Liverpool for about two years) but had decided to take a year out in 1992 to visit New Zealand. Dr O'Flynn said this was not an uncommon thing for junior doctors to do. Dr Fisher had told him that when he arrived in New Zealand he particularly liked Southland and decided to stay. Dr Fisher had told Dr O'Flynn that there was some loose understanding when he came to New Zealand (in 1992) that he would be in a position to continue his psychiatric training here and that he had made some agreement with the hospital that he would be able to work here as a Registrar and receive training from the psychiatric programme in Dunedin. Dr O'Flynn said Dr Fisher had told him that once he was working in Southland the pressure of work, particularly when he was the only "MOSS psychiatrist" on the premises, did not allow him to go to Dunedin for one day a week to participate in the training and, rather than fail or be seen as a poor attendee, he chose the option of withdrawing and postponing his qualification as a psychiatrist. Dr O'Flynn said it was not uncommon for a Registrar, especially in a rural area, to decide not to persist in seeking such a qualification.

399. Dr O'Flynn said that if and when Southern Health achieved accreditation, that would again be possible. He said Dr Fisher was a single man aged about 40, and there was no special reason why he should complete his specialist qualification if he did not wish to do so.

400. The Tribunal finds that Dr O'Flynn did make enquiries of Dr Fisher about his failure to complete the training programme, that Dr Fisher provided him with the explanation referred to above, that the enquiry was adequate, and that the explanation was both acceptable and credible.

401. The Tribunal refers to the assertion that Dr O'Flynn should have made enquiries about Dr Fisher's "personality difficulties" or personality issues.

402. In 2000 Dr Fisher was actively seeking employment as a MOSS in mental health work and Southland was actively seeking to recruit medical staff. Dr O'Flynn said Dr Fisher was not known to him but was known to others at Southland who proposed his appointment and supported it. Based on the information given to him he said there was no reason to look in more detail at the recommendation.

403. In particular, he was informed that Dr Fisher had received three years' training in psychiatry in the United Kingdom and that he had worked for a number of years in New Zealand as a MOSS in psychiatry. For at least part of that period (two years) he had been in a training programme for qualification as a psychiatrist and had been designated a Registrar.

404. Dr O'Flynn said that Dr Fisher had worked in mental health in England and New Zealand for four different employers over a period of 10 years. His New Zealand experience was in Southland and also on the West Coast where he had worked at a senior level in mental health for a period of time. He had held a Registrar's position while in the training course and then when that had not continued he had been a senior MOSS. He was not under any requirement for oversight or supervision.

405. Dr O'Flynn said he was told that Dr Fisher had worked satisfactorily for five years previously in Southland and at one period had temporarily managed the Service. He was also told that he had operated as the sole medical staff, member, and manager, of the Inpatient Unit for extended periods of time.

406. He said he concluded, reasonably in his view, that this would have been with the approval of the Medical Council and the Ministry of Health and Southern Health. This was in a period before his own arrival in New Zealand.

407. Dr O'Flynn said nothing adverse to Dr Fisher's clinical skills or qualifications was brought to his attention.

408. However, he said that he understood that there had been interpersonal issues between Dr Fisher and one or more other staff members. Given what he knew of the period he did not consider this surprising. He added that this could be said of almost every medical member of staff in their department (including himself) who at some time or other had taken issue with the administration. Dr O'Flynn said neither did this seem significant in relation to Dr Fisher's medical competency.

409. He added that he was not advised and there was no suggestion of clinical deficits on the part of Dr Fisher but did remember the issue of personality difficulties being mentioned. However, he said that apart from the Burton tragedy, Dr Fisher generally speaking was no trouble to have on staff. He did not create personality difficulties, was generally liked and generated very few complaints.

410. Dr O'Flynn said that in addition to the absence of any adverse information, he found that Dr Fisher's return was welcomed by a number of staff. While he did have some irritating features (and added that most people do have them) such as a reluctance to work beyond minimum duty hours and a tendency at times to be hard to locate, he otherwise appeared to enjoy the support of the staff who had worked with him previously.

411. Dr Roy was asked by the Director of Proceedings whether he would be more interested in looking at the Human Resources file if there had been some kind of personality issue with the doctor during their previous period of employment. He replied that it depended on what one meant by a personality issue which was not infrequent when dealing with senior doctors.

412. He was of the view that the provision of mental health services was a team responsibility. When questioned whether personality issues can have a detrimental effect on the effective and safe provision of those services, Dr Roy said that in any team one gets an interplay of personalities and in the psychiatric setting, in his experience, personality was more the rule than the exception. It was the Team Leader's responsibility to identify and manage personality issues if they were impacting on the provision of the particular health service.

413. The Tribunal finds that there was no breach on Dr O'Flynn's part if he did not make further enquiries of Dr Fisher's "personality issues" in these circumstances.

414. Dr O'Flynn was definite that he had not been told then, until after Mrs Burton's death, that there had been any issue as to Dr Fisher's medical skills or competence. Had this been so, he would have reacted immediately to any such suggestion. He said he was seeking to achieve accreditation for Southland and could not accept any shortfall in standards. Further, his own commitment and priorities meant that he would not have tolerated such a situation. Dr O'Flynn said that it was to him quite absurd to think that after what he had been through in covering for staff shortages that he would have let an inadequate clinician continue in the Unit.

415. The Tribunal accepts Dr O'Flynn's evidence.

416. The Tribunal does not accept there can be any fair criticism of Dr O'Flynn for failing to carry out reference checks himself or providing direction to someone else to do it, concerning Dr Fisher.

417. The evidence establishes, to a high standard in the Tribunal's view, that at the relevant time it was the policy and practice of Southern Health that these checks would be carried out by the Human Resources personnel.

418. The evidence of Dr Paul, Dr A, the Mental Health Counsellor and Dr O'Flynn himself (all of which the Tribunal accepts) establishes that these checks were undertaken (or understood to have been undertaken) by Ms X in particular.

419. Further, the information which was available to Dr O'Flynn satisfied him, reasonably in the Tribunal's view, that Dr Fisher possessed the appropriate level of skills and experience to undertake the work allocated to him.

420. Under the second particular the prosecution criticised Dr O'Flynn for failing to take adequate steps to "determine the scope of Dr Fisher's practice".

421. Dr O'Flynn rejected the allegation that he had failed to define the scope of practice of Dr Fisher's unsupervised practice.

422. He stated that Dr Fisher returned to a position which he had held before where the scope of his practice had long been defined, known, and operated by all involved.

423. He said there was no precision in the term "unsupervised" as set out in particular two.

424. As a MOSS, Dr Fisher was a participant in meetings of medical staff, on ward rounds, in interaction with colleagues over particular cases, and fully aware of the boundaries of his authority.

425. As in any professional environment, he said Dr Fisher had a subordinate status accompanied by a certain level of authority to act. Dr O'Flynn said this had been defined before he himself had arrived in Southland, had been operated on for years under a succession of Clinical Directors and had been a part of successive Unit reviews. For example, there had been reviews of the Ward 12 inpatient service including audits by an independent external psychiatrist on at least two occasions before his arrival. (Dr O'Flynn added that one of the reviews was by Dr Brown, a prominent Australian psychiatrist who had worked mostly in the administration area and had undertaken a study in the mid 90s with a particular focus on Dr Fisher's sole management of the Service and spoke highly of his management.)

426. Dr O'Flynn stated that having been a Clinical Director for some 17 years, he had discovered that if one dealt fairly and humanely with people they kept one informed. Within the Southland Service he said that no-one considered it a betrayal to talk to him about an issue and that he could be relied upon to make fair decisions in disputes.

427. Dr O'Flynn said his expectation, having been a psychiatrist since 1984, was that a responsible, qualified and experienced doctor would request assistance from a senior colleague when clinically challenged.

428. He had no reason to think otherwise in the case of Dr Fisher who had gone to him with issues when he needed help with them so there was no suggestion that he was incapable of asking for help.

429. Dr O'Flynn said that he had his own significant case load of inpatients in Ward 12 throughout the relevant period so that he had direct contact and involvement with the ward, its operation and the role of Dr Fisher within it. He knew that Dr Fisher had held equivalent positions under a number of other psychiatrists both in Southland and at Hokitika. If there were any need for intervention on his part, then such additional definition of the scope of unsupervised practice would be defined, necessarily, on a case by case basis.

430. When considering the competence, scope of practice, and management of a junior doctor (although bearing in mind that Dr Fisher was a senior member of the medical staff), Dr O'Flynn said he looked at the total picture, that is, qualifications, work experience, personal discussion and review, case outcomes, peer reviews from other staff, and then would exercise his judgment of the doctor holistically. To him, Dr Fisher at the time appeared well suited to his work.

431. In addition, Dr O'Flynn said there were a number of mechanisms which would alert a Clinical Director to possible staff inadequacies, in particular, these included:

(a) Human Resources feedback from reference checks.

(b) Staff discussions and complaints.

(c) Licensing body requirements.

(d) Incident reports regarding a doctor or other clinician.

(e) Direct observation through meetings and ward rounds.

432. Dr O'Flynn said that he monitored these for all medical staff not just for Dr Fisher and no issue arose under any of those headings prior to the death of Mrs Burton.

433. Following his appointment, Dr Fisher gave Dr O'Flynn no cause for concern.

434. He said Dr Fisher brought clinical concerns to him personally and also to their weekly doctors' meetings.

435. He said that he was available to Dr Fisher 24 hours a day and that Dr Fisher knew this, accepted this, and although Dr Fisher contacted him outside meetings only occasionally, he had no reason to doubt that he would bring difficult cases or concerns to his attention.

436. Dr O'Flynn said it was his opinion that the decisions Dr Fisher would be making in Ward 12 on admission and discharge of patients were decisions which should be well within the scope of practice of a physician with three years training in psychiatry and nine years experience in the field.

437. Dr O'Flynn said that one of the safeguards was that staff brought everything to his door. With trained and experienced staff around, it was a mystery to him that no-one brought Mr Trevor Burton's letter to his attention.

438. With regard to Mark Burton, he was discussed at ward rounds with those who were present. Mark was poorly compliant with treatment but he said this was nothing unusual. It is a very common scenario.

439. He said it had been suggested that he had failed to recognise that it was inappropriate to consider Dr Fisher as a psychiatrist. Dr O'Flynn rejected this allegation. He said he was well aware that Dr Fisher was not a psychiatrist. While he had been operating as one "in effect" in New Zealand for a considerable number of years prior to his locum employment in Southern Health in May 2000, he did not assess or deal with Dr Fisher as if he were fully qualified.

440. Dr O'Flynn said that the existence of MOSSs and their use as "in effect psychiatrists" was an aspect of New Zealand medical culture he had not previously experienced. He was aware that Dr Fisher and other doctors on the staff were not qualified psychiatrists but he also knew that New Zealand practice in all centres, and not just in Southland, regarded

them as having a special clinical role in psychiatry, above that of a general practitioner, but below that of a psychiatrist.

441. He said that Dr Fisher was only one of several MOSSs he had to manage. Each was well aware that he was always available and continued to be available at all times for consultation so that no MOSS was required to work unsupported, on their own, or without the ability to involve himself in any decision. All staff were aware of his availability and made use of this on a regular basis.

442. Dr O'Flynn said he made the assumption that Dr Fisher would have the basic competence of any ordinary person and would act rationally and with common sense.

443. Dr O'Flynn stated he never assumed Dr Fisher to be the equivalent of a consultant psychiatrist capable of the degree and depth of subtlety of a fully trained psychiatrist. However he did make assumptions based on the fact that –

(a) Dr Fisher had been a medical practitioner licensed since 1985.

(b) Dr Fisher was consistently in good standing (a technical term) and licensed accordingly without any requirement for "oversight" on his licence. In this regard, he referred to his own experience of gaining entry and approval of vocational registration in New Zealand which he said had been a fairly rigorous process. He believed that the process through which he went was complete and assumed, rightfully or wrongly, that a medical practitioner who did not have a legal requirement for oversight meant just that.

(c) Dr Fisher had worked in Southland Mental Health Services in the past and was highly spoken of by those still employed within the Service such as the Southland Mental Health Emergency Team.

(d) Dr Fisher was reported to have run the Service single handedly with the assistance of Ms Mawhinney in the past. He was informed that he had done a good job when the Service had to operate without any psychiatrists available.

444. The prosecution's case under this particular fails. The Tribunal is prepared to accept that there was a substantial failure on the part of Southern Health's recruitment processes at the time of Dr Fisher's employment. Under the systems that were in place Ms X had particular responsibilities which either were not carried out or were carried out inadequately.

445. The Tribunal accepts that Dr O'Flynn's involvement in the recruitment of Dr Fisher was minimal or peripheral.

446. Dr O'Flynn did not oppose Dr Fisher's employment. He was aware that Dr Fisher had been employed previously for five years and was being re-employed with the support of other senior staff.

447. The Tribunal does not accept that Dr O'Flynn had a duty, in those circumstances, to conduct additional investigations.

Conclusion as to Particular Two

448. For the various reasons set out above, the Tribunal does not find that Dr O'Flynn failed to adequately assess Dr Fisher's experience and/or competence and thereby ensure he met appropriate standards of care. Even though others such as Professor Mellsop and Dr Patton may have been more pro-active in scrutinising appointments of medical staff, having regard to the particular circumstances of Dr Fisher's re-engagement as a MOSS in July 2000, the Tribunal does not consider Dr O'Flynn can be criticised as having failed to discharge his professional responsibilities.

The First Particular

449. The first particular alleges:

> *Between 10 February 2001 and 30 March 2001 failed to ensure that Dr Peter Fisher, Medical Officer Special Scale, the clinician responsible for Mark Burton's care, was adequately supervised*

450. Counsel for the Director of Proceedings submitted that Dr O'Flynn, as Clinical Director, in particular, had a responsibility to ensure adequate support/supervision.

451. It was the prosecution case that there was a failure by Dr O'Flynn to provide clear direction or guidelines in regard to the supervision of Dr Fisher. Ms McDonald submitted there was no systematic review of the performance of Dr Fisher and no monitoring of his practice.

452. She submitted that safe and effective practice suggests that Dr Fisher should have been supervised in some appropriate manner especially if there had been concerns about prior performance or if the standard of recent performance was unknown. Given the importance of work in an acute psychiatric unit, more rigorous supervision should have been arranged for Dr Fisher in his capacity as a MOSS.

453. Ms McDonald submitted that whatever the potential value of the various meetings and interactions between Dr O'Flynn and Dr Fisher none of them separately or cumulatively provided an appropriate forum to ascertain Dr Fisher's competence or experience.

454. She submitted in particular with regard to the "Doctors' meetings" that there were no records or minutes of them, that Dr Fisher was not required to attend them, that they covered a range of issues, and that they were not a substitute for one-on-one supervision.

455. As to the weekly team meetings, these were criticised on the basis that there was not always a psychiatrist present and that Dr O'Flynn attended only two of the five meetings which discussed Mark Burton's case.

456. Ms McDonald criticised Dr O'Flynn's "open door" policy and stated that he essentially left it to Dr Fisher to determine what level of supervision he thought he needed.

457. Ms McDonald also submitted that the use of incident reports and being seen on the ward were plainly inadequate means of supervision.

458. Ms McDonald rejected Dr O'Flynn's defence that Dr Fisher's shortcomings were a "hidden flaw", and implied that Dr O'Flynn should have discovered the "flaw".

459. Further, Ms McDonald submitted that Dr O'Flynn had conceded in evidence that Dr Fisher's supervision was inadequate.

460. Mr Rennie submitted that in 2000/2001 there was no requirement in law for supervision of Dr Fisher.

461. Mr Rennie submitted Dr Fisher was only one of a substantial number of staff who Dr O'Flynn had to manage. The evidence showed that Dr O'Flynn followed a number of procedures in order to provide appropriate management of those staff.

462. Mr Rennie submitted that it was difficult to understand what the breach of conduct is said to be under the supervision element of the charge, as this particular does not define what it is said Dr O'Flynn was obliged to do, which he did not do.

463. Mr Rennie submitted that in considering Dr A's evidence the Tribunal should have regard to the fact that the special and intensive one-on-one supervision of Dr Fisher took place in 2001 in full knowledge of the Burton tragedy and Dr Fisher's role in it.

464. He submitted that Dr A found hidden below a plausible façade, a man who had engaged for years in conscious deception and had been successful in that.

465. Mr Rennie submitted that it could not be professional misconduct to be deceived about such a matter and to act in reliance on what was later found to be false.

466. By the time the evidence concluded it became readily apparent to the Tribunal that there was no precise definition of supervision in the particular circumstances.

467. The evidence was even less clear as to precisely what supervision of Dr Fisher was allegedly required on the part of Dr O'Flynn.

468. Dr Patton stated that *"people with the responsibility for the safety of a service try to manage those aspects of employment of non-specialist medical staff"*.

469. The Tribunal accepts as valid Mr Rennie's submission that the evidence establishes that was what Dr O'Flynn was doing.

470. It would appear that at the material time in 2000-2001 there was no statutory or regulatory requirement for supervision of Dr Fisher. As has already been stated although Dr Fisher held general registration, he was exempt by the Medical Council from a requirement of general oversight.

471. There was no uniformity among the witnesses of what was required of a Clinical Director regarding supervision of senior medical staff within the service for which the Clinical Director is responsible.

472. There was a variation in aims and methods of supervision described by the witnesses.

473. When asked by the Tribunal to categorise the different kinds of supervision, Dr A responded that one of the difficulties they had was the "degree of elasticity" and the "lack of clarity" that they had received from the Medical Council and some other organisations. He said they would benefit from having tight definitions and meanings, for example, the difference between supervision and oversight.

474. Dr Roy, in answer to a question from the Tribunal, said that at the relevant time even if there was a requirement by the Medical Council for "oversight" regarding a doctor's registration there was no definition of what "oversight" was.

475. Dr Roy agreed that "supervision" covered a variety of methods and a variety of types.

476. The evidence before the Tribunal established that the practice in New Zealand varied widely regarding what, if any, supervision a MOSS received. It could vary depending on place, resources, and/or the seniority of the MOSS. Dr O'Flynn, Professor Mellsop, Dr Ryan, Dr Roy, and Dr Patton all commented on the issue. There was also information before the Tribunal from Dr Taumoepeau, the doctor who conducted the audit after the death of Mrs Burton.

477. Dr O'Flynn said he knew that Dr Fisher and other MOSSs on the staff were not qualified psychiatrists but he also knew that New Zealand practice in all centres (not just Southland) was to regard them as having a special clinical role in psychiatry, above that of a general practitioner, but below that of a psychiatrist.

478. Both Professor Mellsop and Dr Patton for the prosecution emphasised the one-to-one method of supervision. However, it was not a requirement of the Southland Mental Health Service at that time that one-on-one supervision be in place for MOSSs.

479. In this regard the Tribunal refers to the policy on "Clinical Supervision of Mental Health Services" for the Southland District Health Board dated 14 February 2001, some six weeks prior to the death of Mrs Burton. This document was designed and approved by Dr O'Flynn who told the Tribunal it was a pastiche of best practice from the literature of not just Australasia but also North America and Britain.

480. This document indicated that the ground work was being laid to have one-on-one supervision for the future.

481. It appears that it was a new policy as it did not supersede any previous policy.

482. Dr O'Flynn explained that it was one of the processes that was not, at that time, fully in place which, he said, was true for 60% of the contents of the mental health blueprint in New Zealand.

483. Professor Mellsop has undertaken a number of roles in his career, including that of Clinical Director in Services for Psychiatry in both Australia and New Zealand (Wellington and Waikato).

484. Professor Mellsop's most recent role in this regard was between 1997 and 2000 as Clinical Services Director/Area Director for Mental Health Services at Health Waikato. At that time his service employed on a permanent basis about five or six MOSSs and twenty psychiatrists.

485. In the Tribunal's view, this complement and number of permanent staff by itself made the Waikato service a somewhat different service from that for which Dr O'Flynn was responsible at the material times.

486. When asked by a member of the Tribunal what kind of supervision those MOSSs would have had at that time, Professor Mellsop was not able to recall the specific arrangement but said there was always *"a formal idea, a formal concept of supervision for each person"*.

487. Asked whether any particular MOSS was practising totally independently, Professor Mellsop said he would have to go back to the staff list and think about the individual persons but that *"there would be nobody who wouldn't have had more oversight than what Dr Fisher had."*

488. Asked whether he had had to improve the supervisory system Professor Mellsop replied *"… You know, there wasn't, that I can recollect, a policy saying MOSSs get this type of supervision. They were determined by, where is this person working and what are their skills and, you know, what do we know about how well they can function and put it in that light. That was what was driving it, not policies and procedures."*

489. In answer to a question from another member of the Tribunal as to how long it had taken him to come to the view about the level of functioning of MOSSs in New Zealand, Professor Mellsop said he was unable to answer that question because he had *"sort of grown up with it"*. He thought it was some period after 1974 that MOSSs *"came into [his] consciousness"* but he would be very hard pressed to know how far back to go to find out.

490. Dr Bridget Margaret Taumoepeau is a consultant psychiatrist practising in Wellington and Porirua. She was not called before the Tribunal but, by consent, a copy of the relevant part of her report dated August 2001 and entitled "Clinical Audit of the Care of Mark Burton by the SDHB Mental Health Services" (which had been presented at the Coroner's Inquest into the death of the late Mrs Burton) was made available to the Tribunal.

491. Under the heading *"Observations of a more general nature related to the provision of Mental Health Services"* at page 370 of her report, Dr Taumoepeau observed:-

> *"Both doctors who cared for Mr Burton during his admissions were medical officers special scale (MOSS) and not qualified psychiatrists. The doctor on the first admission was very experienced. The doctor on the second admission was less experienced. He had worked in Invercargill between December 1992 and January 1997 and again from October 2000 to the present. While working in psychiatry for over 5 years in the Invercargill service, he had not undertaken any formal training during that time. No formal supervision was in place, although the psychiatrists attended the weekly review meetings with the MOSS, so could give some advice and input."*

492. At the conclusion of her report, Dr Taumoepeau made a number of recommendations one of which referred to supervision. At page 380 of her report she recommended:

> *"Medical officers (MOSS) employed by the mental health services need to have formal, regular supervision by a consultant psychiatrist. The terms of reference of supervision should be recorded and should include frequency, length of supervision sessions and content. The content should include a requirement for the medical officer to present all new patients to the psychiatrist and to follow up on recommendations made by the psychiatrist. In other words, the medical officer should be treated as a registrar in terms of supervision and accountability."*

493. The Tribunal also received, by consent, the transcript of Dr Taumoepeau's oral evidence given at the Coroner's Inquest. The Tribunal sets out hereunder an exchange of questions put to Dr Taumoepeau and answers by her.

> *Q. We heard evidence on Friday that Dr Fisher was in fact not under the direct supervision of any consultant psychiatrist, I'm not sure if you were totally aware of that.*
>
> *A. I was.*
>
> *Q. Is that satisfactory?*
>
> *A. I think the whole issue of medical officers and their status, they are used in many places as I think you heard evid, is unsatisfactory, and that is why I made detailed recommendations about supervision, it is a long story about the use of medical officers within psychiatry, to be fair to them they have fallen between two stools, they are neither a qualified psychiatrist who is responsible for their own practice without supervision nor a registrar who*

> *is wrokign (sic) under supervision of a psychiatrist and whose work the psychiatrist takes responsibility and undertakes trining. It is not satisfactory and that situation occurs in many places, not just here."* (meaning Southland) (page 282 l.6-21 Coroner's transcript)

494. This aspect of Dr Taumoepeau's evidence was put to Dr Patton by Mr Rennie, that is, that there were examples of MOSSs not under the direct supervision of any consultant psychiatrist which Dr Taumoepeau had agreed was not satisfactory but had stated it occurred in many places in New Zealand and not just in Southland.

495. Dr Patton responded that to his knowledge there are many places in New Zealand in which there are MOSSs with degrees of supervision; and that the nature of that supervision is determined by a process of matching the skills and experience and abilities of that doctor with the requirements of the job. He said his experience was that people with responsibility for the safety of the Service try to manage those aspects of the employment of non-specialist medical staff.

496. Mr Rennie commented to Dr Patton that the difference seemed to be that what Dr Taumoepeau was saying was that was where the state of Mental Health Services should progress to whereas Dr Patton seemed to be saying that was where it should have been.

497. Dr Patton responded *"absolutely and, in fact, in many places that's exactly where it was"*.

498. It would appear to the Tribunal from the responses of Dr Patton that he was agreeing with Dr Taumoepeau's evidence that, while it was not satisfactory, there were places in New Zealand where MOSSs were not under the direct supervision of any consultants although he thought the recommendations in Dr Taumoepeau's report were directed to the Southland region in particular.

499. Between the period 1999 to 2003 Dr Patton was Clinical Director for the Mental Health Service of South Auckland Health (subsequently known as Counties Manakau District Health Board) and Director of Area Mental Health Services for South Auckland with a

population of approximately 400,000. When he was appointed to those positions, there were MOSSs working in the Service.

500. He was asked by a member of the Tribunal whether every one of those MOSSs had some form of designated supervision at the time he was appointed to the role of Clinical Director. Dr Patton replied that the short answer was *"no, they did not"*. He added that there were several MOSSs who worked in the Service at that time and who worked largely in community teams. He referred to the fact that in each of those community teams there were other specialist psychiatrists working within them and that because of the way those teams worked there was opportunity due to weekly meetings and that the medical staff took responsibility for presenting cases in those forums and the specialists were present during that process. Dr Patton stated that after he arrived in South Auckland he set up the process where each of the MOSSs had supervision individually to the above although the nature of the supervision varied depending on the experience of the MOSS.

501. When asked if there was any Ministry of Health requirement for him to set up this process Dr Patton replied that there was not.

502. Dr Ryan, who is presently employed as a Registrar in Psychiatry by the Canterbury District Health Board, is working in the Forensic Service based at Hillmorten Hospital. (He also worked at that hospital for three months in 1999 for the inpatient Psychiatric Service). He is currently studying towards fellowship with the Royal Australian New Zealand College of Psychiatrists.

503. Between 1999, when he graduated, and December 2002, Dr Ryan found significant differences between the mental health services for which he worked during that period.

504. He said the Canterbury District Health Board Mental Health Service has a high number of psychiatrists in relation to the patient numbers and consequently has little need to employ MOSSs. They had, and have, substantial resources both internal and external available to the Service.

505. At the end of 1999 he was employed by Capital and Coast District Health Board at Wellington Hospital who seconded him to work at Masterton Hospital in the Mental Health Service there for three months. He said that Masterton had very few patients and as a result the environment was quite relaxed. In his assessment there was an adequate complement of psychiatrists and other staff. There was one MOSS and two psychiatrists working in the Service. He gained a good impression of his time at Masterton Hospital. He had contact with the MOSS at Masterton Hospital who, he said, was treated as a consultant by the District Health Board because of the lack of sufficient consultant psychiatrists.

506. In August 2001 he was employed by the Southland District Health Board as a Senior House Officer in the Inpatient Mental Health Unit (Ward 12) where he worked until September 2002. This was during Dr O'Flynn's time as Clinical Director. It was during this time that he decided he wanted to specialise in psychiatry.

507. Following his employment at Southland, Dr Ryan did locum work for three months prior to commencing his training programme at Christchurch. This involved working in Alice Springs in the Australian Northern Territory for the mental health service there for six weeks and working for the Hawkes Bay District Health Board mental health service for two months between October and November 2002.

508. Dr Ryan said that the MOSSs at Hawkes Bay were also treated as having a status virtually that of a consultant and that there appeared to him to be very little direct supervision of them. From what he observed, they operated autonomously as a consultant psychiatrist would.

509. Dr Roy stated that MOSSs have been and continue to be given the responsibilities of psychiatrists in many mental health services around the country, particularly where there are shortages of psychiatrists. He said they often do the same job as a psychiatrist. Some of the MOSSs receive almost no supervision and some are supervised as much as a Registrar. He said that the degree to which a MOSS is treated as a psychiatrist depends very much on the number of psychiatrists. He explained that in those lucky areas where there are sufficient psychiatrists to supervise the MOSSs then the MOSSs have a lesser

degree of responsibility, but that in most of the rural or provincial areas of New Zealand the MOSSs have, both in the past and now, significant responsibilities.

510. Dr Roy told the Tribunal that in reality, in the provincial services, the method of supervision of a MOSS is based on the training model. There is an expectation that a junior staff member will approach a more senior clinician if he or she perceives they require assistance. This is driven by the junior doctor, particularly where the more senior doctors are very busy trying to look after their own patients.

511. He described the supervision arrangements as *"puzzlingly ad hoc"* to someone outside medicine and to understand the situation it was necessary to understand the history of the supervision relationship. He stated that traditionally hospitals have been manned for 24 hours per day 7 days a week by junior doctors with a regular Monday to Friday attendance by seniors so that an arrangement had to be in place to allow backup for the juniors should they require it. If junior doctors felt out of their depth then there was a system to allow them to seek assistance. That system is, in management terms, bottom up so that help is initiated by the junior doctor. In a training situation the supervisor takes on additional responsibilities but supervision was initially to provide assistance in specific cases.

512. He said that the ad hoc appearance related from the fact that intervention by senior doctors is largely driven by juniors and that there was a general expectation that requests for help will diminish as the junior gains experience.

513. He referred to the fact that in recent years there has been an increasing tendency for management to be "top down" with an audit of performance and that the audit has tended to concentrate on the performance of senior doctors.

514. He said that the "top down" and "bottom up" systems do not entirely mesh and the nature of the supervision relationship has never been exactly established. He said there has never been a specific requirement for audit and audit has never been a routine part of supervision and that this is still true today.

515. In answer to questions from a member of the Tribunal, Dr Roy said that when he joined the Hutt Mental Health Service in 2000 he could not be sure if all the MOSSs were supervised but in due course they took care to ensure that they were. He said that this was about two years ago, partly in response to the Burton case.

516. He said this involved ensuring that each MOSS was allocated to a vocationally registered specialist psychiatrist and that during the last three to four years he has supervised a MOSS.

517. When asked what the key objectives in his supervision session with the MOSSs were, Dr Roy replied that it is almost always a discussion of difficult cases about patients who do not respond to treatment, patients refusing treatment, difficult diagnoses, patients with multiple pathology and that type of thing.

518. When asked whether he would be testing the MOSS's knowledge and approach, Dr Roy replied that there would be no aspect of testing in it. The MOSS would bring the case to him which was usually a demanding case but Dr Roy was not testing the MOSS.

519. Asked if the strength and areas where the MOSS's knowledge and skill required improvement would be revealed in the course of this process, Dr Roy said that was difficult to answer because the MOSSs are experienced so that the cases they raise for discussion would be difficult for everyone and it therefore did not especially reveal a weakness in the MOSS. He said generally speaking sometimes a MOSS would like to talk about a difficult case.

520. Following a further exchange of questions and answers with another member of the Tribunal, it was apparent that insofar as Dr Roy's evidence went, there was no particular definition of oversight and no particular definition of supervision in relation to MOSSs.

521. Dr Roy agreed that supervision covered a variety of types and methods.

522. With junior doctors he said that a large part of it was just imparting information. With the more senior doctors, often the problems they were bringing were intractable and that it

was not what Dr Roy might be telling them they needed to do but rather reassuring them there may be something they had not looked at. Those were one-on-one interviews.

523. Dr Roy said that when he was in the inpatient unit he did ward rounds which were illuminating but that in the inpatient unit it was more difficult because psychiatrists worked in parallel and also there was peer review. He explained that peer review is separate from supervision in that the peer review is supposed to be confidential to the particular group which one is not allowed to use in other contexts.

524. When asked whether supervision of a house surgeon differed from a registrar in training, Dr Roy said that the supervision was very different and that with regard to the house surgeon sometimes he would have to tell them some medical facts, let alone psychiatric ones.

525. The house surgeons (who are junior) were closely supervised. They would see the patients together in the morning and then they might be allocated a case to go and see and then they would talk about it afterwards so that they did not do very much at all by themselves. This was more in the apprenticeship style of supervision.

526. With regard to persons being appointed under the MOSS system, he considered them part of the senior medical staff.

527. With regard to MOSSs he has supervised, he described them as, on the whole, having been *pretty smart* and that if he did not agree with them it crossed his mind that it might be they who were right and he who was wrong.

528. The informal part of the supervision was the conversation in the corridor which he said was probably the larger part of the supervision.

529. Dr A said that before the Burton case, he had formed no opinion of Dr Fisher's competence.

530. From what he saw of him, Dr Fisher had not rung his alarm bells as he appeared plausible, sounded quite agreeable, said the right things and appeared to be obliging. Dr A was not aware of any expressed concerns about his competence.

531. After the unfortunate death of Mrs Burton, Dr A was asked to "supervise" Dr Fisher. Southern Health imposed a stringent supervision regime over Dr Fisher. The form of written contract, negotiated with Dr Fisher was signed by him on 31 October 2001. There are no less than seven signatories to it – Dr Fisher, Dr A, Dr O'Flynn, Ms Kitson, Dr Shaw (the Medical Adviser), Dr Paul and the Chief Executive.

532. This was no ordinary supervisory arrangement. As Dr A said, he had never produced as "draconian a contract of supervision", and he had "never ever provided this level of scrutiny of anybody before".

533. It was only when Dr A was supervising Dr Fisher directly and observing him extremely closely that he was able to find and determine that his skills were questionable and illusory.

534. Dr A said it became clear to him that Dr Fisher would not openly and transparently tell him everything he needed to know in a reliable and collegial manner.

535. He said it was necessary for him to engage the assistance of third parties to determine both where Dr Fisher was and also what clinical or other activities he was engaged in.

536. With regard to Dr O'Flynn, Dr A believed Dr O'Flynn would never have had available to him the time to delve into Dr Fisher's practice to the degree which he (Dr A) was obliged to do in order to reach the conclusions about Dr Fisher's practice.

537. Dr A found it, in fact, essentially a full time job. When cross-examined about this, Dr A said by "full time job" he meant more than fifty hours a week.

538. Dr A explained, during cross-examination, that he had difficulties in terms of Dr Fisher telling him things that subsequently he was able to identify were untrue; that "he was very difficult to pin down"; "he was duplicitous"; and if one had any distraction "he was gone"; that Dr Fisher could look him "straight in the eye" knowing that he (Dr A) had available to

him information which would establish the true position "and just lie"; that when one was dealing with Dr Fisher (and people like him) it was "like dealing with a photo and each photo in isolation can look and appear okay but when you put them together it doesn't make a video".

539. Dr A said it was becoming increasingly obvious to him that Dr Fisher was making no attempt to meet either the spirit or the letter of the supervisory agreement.

540. It became wearying and alarming which caused Dr A to write to Dr O'Flynn on 18 January 2002 stating that he could not supervise Dr Fisher.

541. Ms McDonald put to Dr A that it could be taken from his letter that he had concluded that Dr Fisher was unable to present/discuss clinical details of a patient. Dr A replied it was not his conclusion. What he had concluded was that Dr Fisher "was unwilling, not unable".

542. This led ultimately to Dr Fisher being removed from all clinical patient care responsibility and eventually to a leave of absence from the Service following an internal disciplinary inquiry.

543. Dr O'Flynn was asked by a member of the Tribunal what he meant by Dr Fisher's actions regarding his management of Mark as "failures of common sense".

544. He referred to the letter from Mr Burton (a policeman for almost thirty years) which had predicted in express terms the potential danger which Mark could do to his family which letter Dr Fisher saw and did not act on nor bring to attention.

545. Dr O'Flynn said he would have expected anybody to have been alarmed by that letter and to have reacted to it, be they a MOSS, a psychiatrist, or a chartered accountant.

546. The more common usage of supervision in medicine in a wider setting is that of a consultant or other member of the senior medical staff who supervises the junior medical staff caring for the patients admitted under the senior medical staff (or admitted under the lead senior clinician).

547. Supervision in its more circumscribed meaning has been applied in a different context, as in this case by the prosecution.

548. The circumscribed one-on-one supervision, explained by Professor Mellsop and Dr Patton, had its origin in the requirement for post-graduate psychiatric training.

549. This concept is now becoming more widely used in psychiatry. However, in February/March 2001 while it may have been a desirable practice it was not uniformly practised throughout New Zealand, particularly in the provincial centres. These included such centres as Hawkes Bay, Masterton, Timaru and Southland about which the Tribunal has received evidence.

550. There was considerable evidence before the Tribunal that there was overview of the Southland Mental Health Service which included overview of Dr Fisher. Much of this evidence is referred to above.

551. As Dr O'Flynn explained in his evidence, a key strategy in his management approach was to pursue and achieve formal accreditation of Southland Mental Health Services. This was all about developing and building systems.

552. Despite the many setbacks, he continued in that quest. He convened and conducted discussions amongst mental health senior management as to whether he had reached a point where it was impossible to continue. Those discussions examined, as a serious option, the option of closing the Mental Health Service. On each occasion they concluded that they were continuing to hold the baseline, making small but steady improvements and that patient services were at or above the minimum standards.

553. Building the Service to full accreditation could not be achieved overnight. While their problems were severe, they persisted and Dr O'Flynn, together with a committed and, indeed, dedicated team achieved full accreditation and certification in 2003.

554. Whilst, at the end of a lengthy and intense cross-examination, Dr O'Flynn conceded that Dr Fisher had not been adequately supervised, the Tribunal does not accept that it was fair

to conclude from that answer that he accepted responsibility and that it constituted an admission to the first particular.

555. The Tribunal is satisfied that was a concession made with hindsight.

556. There is much force in Mr Rennie's submission that when something untoward occurs there is a temptation to "reason backwards from the events" which have occurred.

557. The focus too easily becomes what are the things which, if they had been done, might have led to a different outcome.

558. Dr O'Flynn was not faced with dealing with the specific case which Dr Fisher was faced with.

559. Dr O'Flynn had a wide range of responsibilities which he had to discharge within the time and resources available to him.

560. He set his priorities in a thoroughly responsible manner and allocated his work and that of his staff accordingly.

561. In the Tribunal's view, the appropriate level for Dr O'Flynn as Clinical Director in February/March 2001 at Southland Mental Health Services was to use multiple methods to allow him an overview of the quality of the service provided by the clinicians within it. One-to-one supervision was neither practicable nor realistic.

562. It is easy with hindsight to criticise the failings which Dr Fisher had and attribute blame to those who were ultimately responsible for the provision of mental health services. The fact is Dr O'Flynn had no reason to believe Dr Fisher had the shortcomings which were discovered only after Dr A supervised Dr Fisher intensively following the discovery of the serious errors in his treatment of Mark Burton. In the absence of any specific knowledge as to Dr Fisher's shortcomings as a practitioner, Dr O'Flynn was entitled to expect Dr Fisher to conduct himself to a standard commensurate with his qualifications and experience as a senior member of the medical staff who had been recommended by one of his peers, herself a MOSS in psychiatry of 20 years experience.

563. In reaching this conclusion, the Tribunal has adopted the objective test referred to by Venning J in *McKenzie v MPDT and Director of Proceedings* (above).

Conclusion as to Particular One

564. For the reasons the Tribunal has set out, it is not satisfied that the prosecution has established that Dr O'Flynn failed to ensure that Dr Fisher, the Clinician responsible for Mark Burton's care, was adequately supervised.

565. Even if some criticism is made of the absence of a formal supervisory regime at Southland Mental Health Services, the Tribunal is not satisfied that there was a failure by Dr O'Flynn which could possibly merit the description of professional misconduct or invite disciplinary sanction

Dr Salanguit

566. Dr Filipinas Salanguit is a consultant psychiatrist having qualified in the Phillipines in 1964. Between October 2000 and May 2001 she was employed at Southland Hospital as a consultant psychiatrist working mainly within the inpatient service.

567. Ms McDonald on behalf of the Director of Proceedings sought to put in evidence an unsworn affidavit of Dr Salanguit. She explained that extensive efforts had been made to locate Dr Salanguit without success. It was possible she was either in the Phillipines or the United States of America. The Tribunal accepts that such efforts were made.

568. It seems Dr Salanguit did not give evidence at the trial of Dr Fisher.

569. Mr Rennie objected to the admission of Dr Salanguit's unsworn affidavit.

570. The Tribunal agreed to receive it with the usual safeguards.

571. However, in view of Dr Salanguit's absence, which means that she could not be tested by cross-examination, it would be wrong to draw any adverse inference from it. In fairness to both parties the Tribunal has not attributed any weight to it.

The HDC And Other Inquiries By External Agencies

572. We have referred to the various inquiries and hearings which took place following Mrs Burton's death.

573. Dr O'Flynn told the Tribunal that following this tragic event, he and the staff of the Mental Health Service had to respond immediately to all inquiries, at all levels including hospital, professional, police and Ministry.

574. He said the staff, already seriously under strength, had to respond to those inquiries, achieve their own personal reconciliation with the tragedy that had occurred, and continue the operation of the Service in as nearly a normal manner as possible.

575. Dr O'Flynn said it would have been of assistance to have been provided with relief staff and additional staff but little could be achieved in the short term and in reality they continued to operate the Service and accept the additional workload.

576. All of Dr Taumoepeau's recommendations were addressed.

577. However, it was the HDC's inquiry which Dr O'Flynn said caused him and the staff the most distress. He described the process of the inquiry, and the subsequent findings by the Commissioner, in strongly critical terms and remains angry and deeply resentful about them.

578. He referred to the various criticisms made of him by the Commissioner in his report which Dr O'Flynn said accused him of using language that was "stigmatising" and "paternalistic" and which he refuted entirely.

579. Dr O'Flynn gave examples to the Tribunal of what he perceived as unfounded criticisms, and provided explanations for them.

580. Dr O'Flynn said that having dedicated 20 years of his life to working with children, adolescents and adults with mental health problems, and having fought against

stigmatisation and prejudice (on behalf of his patients), he deeply resented being "misrepresented" in the HDC's report.

581. He was also concerned that Dr Patton, in this hearing, appeared to be relying on some extracts from the transcript of his interview which he said were taken out of context.

582. With regard to the HDC investigation, Ms McDonald stated that when a tragedy occurs such as the death of Mrs Burton in these circumstances, it is an unfortunate but inevitable consequence that staff will be questioned, sometimes more than once, about events. Ms McDonald said there was no doubt that many staff members felt particularly stressed by this process but that did not negate the need for the Health & Disability Commissioner to discharge his responsibilities and investigate.

583. The Tribunal has given careful consideration to all the evidence before it, both oral and written, regarding the various inquiries and reports. We have seen and heard the witnesses, some of whom were not interviewed during the Commissioner's investigation. We have seen also the correspondence written by and on behalf of Dr O'Flynn taking issue with the HDC's provisional report and the response of the HDC including his comments in his final report at pages 5 to 7 under the heading "How The Investigation Was Conducted".

584. While the HDC interview with Dr O'Flynn and the various extracts from documents presented to the Tribunal during this hearing provide a background, the Tribunal has weighed them in the context of the entire evidence before it. They are of limited weight only as regards the present charge.

585. It is not this Tribunal's function to enter into debate about the HDC's findings, but it can make its own independent findings on the evidence before it.

586. This Tribunal, having had the benefit of seeing and hearing Dr O'Flynn and the many other witnesses who attested before us, is unanimously and firmly of the view that Dr O'Flynn is deeply committed to the welfare of his patients and of all those patients who have access

to the Service. We do not find any trace at all of "stigmatisation" or "paternalism" in Dr O'Flynn's philosophy or practice. Quite the contrary.

The Burton Family

587. The Tribunal wishes to extend its sympathy to the members of the Burton family. It acknowledges the care which Mr Trevor Burton and the late Mrs Paddy Burton took of their son Mark. They made every effort and did all that could reasonably be done to ensure that Mark was given the best possible help. The tragic outcome was no reflection at all of any action or omission on their part.

Orders and Conclusion

588. The Tribunal therefore makes the following orders:

(a) The charge of professional misconduct laid against Dr O'Flynn is dismissed.

(b) A permanent order pursuant to section 106(2)(d) of the Medical Practitioners Act 1995 prohibiting the publication of the names of the following persons:

(i) xx.
xx is to be referred to as a mental health needs assessor.

(ii) xx.
xx is to be referred to as Community Mental Health Nurse.

(iii) Ms X.
Ms X is to be referred to as Ms X a former member of staff.

(iv) xx.
xx is to be referred to as a drug and alcohol counsellor.

(v) Mr Y.
Mr Y is to be referred to as a Mental Health Counsellor.

(vi) Dr A.
Dr A is to be referred to as a Senior Consultant Psychiatrist.

(vii) xx.
xx is to be referred to as a Medical Superintendent at another hospital.

(c) As a result of the Tribunal's decision, there are no issues as to penalty or costs.

DATED at Wellington this15th day of July 2004

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Sandra Moran

Senior Deputy Chair

Medical Practitioners Disciplinary Tribunal