NOTE: PUBLICATION OF NAME, ADDRESS, OCCUPATION OR IDENTIFYING PARTICULARS OF COMPLAINANT PROHIBITED BY S 203 OF THE CRIMINAL PROCEDURE ACT 2011.

IN THE COURT OF APPEAL OF NEW ZEALAND

CA66/2016
[2017] NZCA 116

BETWEEN	BRUCE JAMES SPITTLE Appellant
AND	THE QUEEN Respondent

Hearing: 15 November 2016

Court: Winkelmann, Duffy and Whata JJ

Counsel: A H Waalkens QC and H C Stuart for Appellant
Z R Johnston for Respondent

Judgment: 7 April 2017 at 2.30 pm

JUDGMENT OF THE COURT

The appeal is dismissed.

REASONS OF THE COURT

(Given by Whata J)

[1] The appellant, Dr Spittle, was convicted of two charges of indecent assault against a mental health in-patient, W, following a jury trial before Judge Crosbie in the District Court. He now appeals his convictions on the basis that the verdicts were ones which a jury could not reasonably reach.

Background

[2] In 1999 W was admitted to Ward 10C of a New Zealand hospital. She was suffering from a number of mental health disorders, including Borderline Personality Disorder (BPD), and was admitted after numerous suicide attempts and drug overdoses. Dr Spittle was a psychiatrist at the hospital and W was one of his patients. Dr Spittle took a close interest in W's care and was actively involved in the execution of her multidisciplinary treatment plan, which included trips with W to a local ice-skating rink to help with her socialisation.

[3] On the Crown case two incidents of sexual abuse occurred between May and September 1999. On the first occasion, during one of the ice-skating trips, Dr Spittle parked his car in a secluded side street and encouraged W to touch him and to allow him to touch her. The touching was said to have included contact with the W's stomach, arm, breasts, groin and bottom, as well as hugging. W also claimed that she could feel an erection at one stage.

[4] The second incident was said to have occurred at Ward 8A of another hospital, where W had been transferred after a period of self-harm. Dr Spittle visited her in her bedroom in Ward 8A, drawing the curtains, slipping his hands under the complainant's sheet, placing one on her breasts and the other on her groin. W said he pinched her causing bruising and then stroked her genital area.

[5] After a short stay at Ward 8A, W was returned to Ward 10C. The multidisciplinary team then decided to transfer W to a secure ward, Ward 9B. Once there, Dr Holdaway assumed responsibility for W's care. Nevertheless, Dr Spittle continued to visit W on Ward 9B. W complained about this, which is recorded in a letter from Dr Holdaway to the manager of mental health services at the hospital. No mention is made in that letter of any sexual contact but W's distress at Dr Spittle's approach to her care is noted, including inappropriate touching.

[6] Dr Spittle responded to this letter. He apologised for errors of judgment but rejected any implication of an abuse of power and provided an assurance that there was no sexual component to his feelings for W.

[7] No formal complaint of sexual touching was made by W until 2012. In the intervening years, W received extensive treatment for her mental health disorders. This included exploration of issues of sexual abuse as a potential explanation for her disorders.

Grounds for unreasonable verdict

[8] On appeal, Mr Waalkens QC for Dr Spittle claims the majority verdicts were unreasonable. He says that the jury must have been wrong about W's credibility and reliability. His key points were:

(a) W's evidence was inconsistent with the available independent and documentary evidence in a number of material ways;

(b) there is no mention of sexual touching in Dr Holdaway's 1999 letter of complaint and Dr Spittle's response was consistent with the evidence;

(c) W's constellation of mental health issues, including BPD and dissociation, created a high risk of her misinterpreting Dr Spittle's behaviour; and

(d) her capacity for distortion and suggestibility, in the context of counselling, led to her making false complaints.

[9] These points are explained and addressed more fully in the assessment that follows.

Jurisdiction

[10] This is a first appeal against conviction under the Criminal Procedure Act 2011. The relevant provision is as follows:

> **232 First appeal court to determine appeal**
>
> …

(2) The first appeal court must allow a first appeal under this subpart if satisfied that,—

(a) in the case of a jury trial, having regard to the evidence, the jury's verdict was unreasonable;

…

[11] A verdict will be unreasonable if, having regard to all the evidence, the jury could not reasonably have been satisfied to the required standard that the defendant is guilty.[1]

[12] The test of reasonableness is informed by the following principles stated in *R v Munro*[2] and approved by the Supreme Court in *R v Owen*:[3]

(a) The appellate court is performing a review function, not one of substituting its own view of the evidence.

(b) Appellate review of the evidence must give appropriate weight to such advantages as the jury may have had over the appellate court. Assessment of the honesty and reliability of the witnesses is a classic example.

(c) The weight to be given to individual pieces of evidence is essentially a jury function.

(d) Reasonable minds may disagree on matters of fact.

(e) Under our judicial system the body charged with finding the facts is the jury. Appellate courts should not lightly interfere in this area.

(f) An appellant who invokes s 385(1)(a) [of the Crimes Act 1961] must recognise that the appellate court is not conducting a retrial on the written record. The appellant must articulate clearly and precisely in what respect or respects the verdict is said to be unreasonable and why, after making proper allowance for the points made above, the verdict should nevertheless be set aside.

[13] Mr Waalkens emphasised that undue deference should not be given to the jury's assessment based on demeanour, citing Canadian authority.[4] He submitted that greater weight should be given to factors such as the consistency of the witness' evidence with other evidence in the case. It is unnecessary to comment on this

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1 *R v Owen* [2007] NZSC 102, [2008] 2 NZLR 37 at [17].
2 *R v Munro* [2007] NZCA 510, [2008] 2 NZLR 87.
3 *R v Owen*, above n 1, at [13].
4 *Faryna v Chorny* [1952] 2 DLR 354 (BCCA).

authority as the relevance of demeanour on appeal from a jury trial is squarely addressed by the *Munro* principles — appellate review will appropriately account for the jury having seen and heard the witnesses. Relevantly, the Supreme Court recently rejected a submission that juries could derive no benefit from demeanour.[5]

[14] Mr Waalkens also invited us to take into consideration that the jury reached majority verdicts as opposed to unanimous verdicts. No authority was cited in support of this proposition and we see no reason in principle to place less weight on a majority verdict.

The evidence

[15] At trial, the Crown called evidence from the complainant; from medical staff responsible for her care at the time of, and soon after, the alleged offending, as well as expert evidence on mental health disorders. For the defence, Dr Spittle gave evidence together with supporting character witnesses and expert evidence about the effect of W's mental disorders and counselling on her reliability.

W

[16] W provided a detailed account of her time in Dr Spittle's ward. She recalled Dr Spittle spending hours with her, sharing personal details and taking the opportunity to be physically close to her, including holding her hand. She recounted having complained loudly about the physical touching. She described the incidents of sexual touching in detail. She described feeling under Dr Spittle's control because of his powers under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and believed he was keeping her in Ward 10C. W provided a number of reasons for not complaining about the sexual touching, including her Christian upbringing, immaturity, shame, embarrassment, and Dr Spittle's seniority — noting that she would come off second best and that he used the threat of sectioning repeatedly.

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5 See *Taniwha v R* [2016] NZSC 123, [2017] 1 NZLR 116 at [41]–[42].

[17] W also provided an account of the background to her formal complaint. She said she was receiving counselling at the time and that her memories of Dr Spittle were triggered by an incident involving a father caught taking indecent photographs up the skirt of a four-year-old girl.

[18] W was extensively cross-examined on the matters underpinning the appeal. We return to these matters when we address the grounds of appeal. For present purposes, it is sufficient to note that W did not recant her complaints in any material respect.

Other Crown evidence

[19] The Crown called evidence from staff who worked with Dr Spittle in 1999, including Marnie Bow, Catherine Smith and Robyn Francis. Detective Glover produced medical notes relating to the period under scrutiny. Their evidence individually and collectively provided immediate context to the charged offending, confirming among other things that Dr Spittle spent lengthy regular sessions with W and travelled with her on the ice-skating trips. Cross-examination elicited favourable comments about Dr Spittle's professionalism and confirmation that the ice-skating was part of a multidisciplinary plan. This evidence also confirmed that there was no recollection or record of complaints about touching while W was on Ward 10C.

The letter(s) of complaint and Dr Spittle's response

[20] Dr Holdaway (a senior psychiatric registrar in 1999 at Ward 9B) gave evidence about her letter of complaint and Dr Spittle's response. The letter included detail about claims of very lengthy counselling sessions, unwanted visits (including on Ward 8A), demands for a close relationship, threats of sectioning, personal disclosures (including about his family), and physical closeness and touching by Dr Spittle including hand-holding and contact with knees. Dr Spittle's response explains among other things that his contact with W was part of an approved multidisciplinary plan. He denies the allegations of inappropriate physical touching but admits it was wrong for him to become so involved with her. We return to these exchanges below at [37].

Dr Spittle

[21] Dr Spittle described his approach as client-centred and that he was schooled in the philosophy that "touching is healing". He described at length his dealings with W. He said that he was not her psychological therapist but as her condition became more severe he spent time with her on several occasions a week, for periods of perhaps half an hour. He referred to his son's illness and likened it to W's situation and acknowledged that he lost some sense of proportion and tried overly hard to help her.

[22] Dr Spittle denied W's allegations of sexual touching as "completely not based on reality", as well as other claims of inappropriate touching, unduly lengthy consultation sessions, that he insisted on a close relationship, kept her in Ward 10C and/or threatened to section her. He accepted that he shared information about his personal interests with W but denied talking to W about his family, describing this allegation as part of W's elaborate edifice. The complaints made in the letter of October 1999 are also largely denied.

[23] Dr Spittle acknowledged that he went beyond the bounds of an appropriate professional relationship, that it was unwise in retrospect and gave rise to a lot of difficulties. Nevertheless, Dr Spittle maintained that the offending never occurred.

Felicity Greenfield / Evan Mason / David Jaegard / Trudy Russell

[24] Ms Greenfield, Ms Russell, Dr Mason and Mr Jaegard are health professionals with direct knowledge of Dr Spittle's work. They provided supporting character evidence, noting that while aspects of his work were unorthodox, including its therapeutic components and offsite excursions, Dr Spittle was a highly professional, compassionate and caring psychiatrist.

Expert evidence

[25] Susan Blackwell and Ian Goodwin provided expert evidence on the effect of mental health disorders on memory, including problems with recovered memory, dissociation and transference. Their expertise and qualifications are not challenged.

It was common ground that W suffered from a number of mental health disorders including BPD and that W's mental health disorders may have had an impact on her perception of Dr Spittle and on her memory. The nature and extent of this impact was not agreed.

[26] Relevantly, Dr Blackwell said:

(a) BPD patients do not differ from healthy control subjects in terms of their ability to memorise emotional information and a survey of psychological literature suggests people may recover or recall memories or traumatic events such as sexual abuse after a long period of time during which they have partially or completely lost access to those memories. Such memories can be as reliable or just as fallible as continuous memories of a past event.

(b) It is a misconception that a victim of sexual assault will always scream for help as soon as he or she is able. The trauma of sexual assault can cause feelings of shame and guilt which might inhibit a victim from making a complaint. Women sexually assaulted by non-strangers are more likely to keep their victimisation secret because of guilt and shame, and are less likely to believe themselves deserving of sympathy and professional help. Many reasons have been suggested as to why many adult victims do not report sexual assault. These include not knowing the assault was legally a crime, denial and suppression, fear of retaliation, fear of being disbelieved and blamed, fear of loss of privacy and fear of being involved in the criminal justice system.

(c) There is no clinical evidence to support the proposition that the combination of BPD and other disorders can result in memory distortion or contamination or that recovered memories are less reliable.

(d) There is no empirical evidence to support the notion of transference in relation to sexual conduct or that people with BPD are more likely to distort actions. She accepted, however, that persons in a vulnerable mental health condition may be more susceptible to somebody in authority indicating something to them and being more likely to believe it.

[27] By contrast, Dr Goodwin gave the following opinion evidence:

(a) There is a high propensity or risk of a patient with BPD misinterpreting things: they struggle to be consistent in terms of how they interpret social interactions, particularly with staff on units. Patients can, for example, entirely misinterpret the actions of a staff member towards them and they can form unrealistic or inappropriately intense relationships.

(b) There is very good research that people in positions of authority are more easily able to suggest to people that things have happened and he sees all health professionals as persons of authority.

(c) Transference arises when in the therapeutic transaction or the therapeutic relationship the patient develops feelings that may have come, or have arisen unconsciously, from previous experience (for example, a person who has been abused by an authority figure may attach via a transference mechanism to the therapist some of the feelings they had toward the person that assaulted them).

(d) Recovered memory is a controversial term, referring to recovery of previously inaccessible memory, and it is possible to have memories of things that have not occurred.

[28] Under cross-examination Dr Goodwin accepted there can be valid reasons for delays in reporting sexual abuse, such as shame and guilt, but that a cautious approach needs to be taken to recovered memories. He emphasised that professional

bodies have urged extreme caution about the reliability of recovered memories. He also agreed that there is no empirical basis to suggest that people with BPD are more likely to distort facts and there is no evidence proving (or disproving) transference in sexual cases.

The closings and summing-up

[29] The key matters raised on appeal formed part of the case put to the jury by Mr Waalkens and were largely summarised by Judge Crosbie in his summing-up including that Dr Spittle's contact with W was known to staff, was consistent with a client-empathetic approach and, conversely, W's account was not corroborated by independent evidence. The competing expert positions about the implications of W's mental health conditions were also carefully explained to the jury.

The key points on appeal

[30] We address each of the main points raised before addressing the threshold test in light of all of the complaints and the evidence.

Inconsistency with the medical records

[31] Mr Waalkens contended that the available independent and documentary evidence is inconsistent with W's evidence in a number of material ways:

(a) the evidence of the Ward 10C medical staff and contemporaneous medical notes do not corroborate any of W's claims about Dr Spittle's alleged behaviour, including that she complained loudly about hugging and hand-holding;

(b) W's assertion that Dr Spittle threatened her with sectioning under the Mental Health (Compulsory Assessment and Treatment) Act was not supported by the medical records. Those records show that other staff had discussed the issue of "sectioning" with her and she had been made well aware of her rights in this regard;

(c) W's assertion that Dr Spittle sought to keep her on his ward is contradicted by the medical notes showing that he sought out options for transfer;

(d) W's allegations about the timing and extent of Dr Spittle's contact with her are not supported by the medical notes;

(e) it is implausible for the offending to have occurred in a four-to-six-person bedroom on a very busy medical ward;

(f) W's complaints about Dr Spittle are not reconcilable with contemporaneous medical and nursing notes recording that she enjoyed her experiences ice-skating, was happier after seeing Dr Spittle on her return from Ward 8A to Ward 10C, and was unhappy about being shifted to Ward 9B;

(g) the medical notes show that risk of self-harm was the reason for transfer to Ward 9B, not to get her away from Dr Spittle as alleged by Dr Holdaway; and

(h) the available notes show that Dr Spittle's treatment of W, including ice-skating trips, was part of an approved treatment plan.

Assessment

[32] We see nothing in Mr Waalkens' point set out at [31(b)] above. The fact that other staff discussed sectioning with W is not inconsistent with Dr Spittle having threatened W with sectioning. However, we agree with Mr Waalkens that aspects of W's account are not supported by the available medical records. There is no Ward 10C record of W complaining about any of the alleged touching by Dr Spittle to the nurses, Dr Spittle actively seeking to section her, or to keep her on his ward. There is also no record of W requesting to be separated from Dr Spittle until she was transferred to Ward 9B. Conversely, there are records reporting that she appeared happier after seeing Dr Spittle. Furthermore, the records do not appear to support her account of the timing and duration of her sessions with Dr Spittle and there are

records suggesting that her social activities with Dr Spittle formed part of an approved treatment plan, that she reported enjoying some of the trips to the ice-skating rinks with him and that she was in fact not happy about moving to Ward 9B. Her letter of complaint also refers to unwanted attention by other men and there is evidence that she made a false complaint of sexual assault against her father, but not Dr Spittle. There is also no record of her bruising at the time of the second incident.

[33] Balanced against this is the following:

(a) Several aspects of W's account are supported by the evidence, including:

(i) the overly attentive way Dr Spittle dealt with her;

(ii) he physically touched her, including hand-holding (as Dr Spittle conceded in cross-examination);

(iii) he told her about personal matters;

(iv) he took trips with W alone to the ice-skating rink;

(v) he visited her on Ward 8A behind curtains; and

(vi) he visited W on Ward 9B even though she was not then subject to his supervision.

(b) The apparent inconsistencies on key matters between her account and the records were plausibly explained by W:

(i) she attributed her failure to complain at the time about sexual touching to fear of being sectioned by Dr Spittle under the Mental Health (Compulsory Assessment and Treatment) Act; her desire to be allowed to visit the ice-skating rink; her confusion about the illegality of the touching given she was

over 16; and shame at having engaged in sexual touching and being sexually stimulated; and

(ii) she was unhappy about being transferred to Ward 9B because she was distressed about being moved to a secure ward.

(c) Aspects of Dr Spittle's behaviour with W were unusual and at times unprofessional, bolstering the prosecution case and casting doubt on the credibility of his innocuous account of his relationship with W.

(d) He admitted in his response to Dr Holdaway's letter that he had an inappropriate "connection" with W, including "controversial" use of touch, "sharing of part of [his] life with her", "self-discovery (or self-disclosure)",[6] longer than ordinary consultations and "explaining to [W] that we needed to develop the relationship". While he denied any sexual touching (which had not in fact been alleged at the time), his response to the letter of complaint corroborated several key features of W's original complaint and evidence.

(e) We also agree with Ms Johnston for the Crown that some of the inconsistencies between W's account and the record on matters of detail can be reasonably attributed, at least in part, to the passage of time, human error and, perhaps, deficiencies in record keeping.

[34] In the result, W's account was supported by independent evidence and key inconsistencies were plausibly explained. While her evidence on peripheral matters was at times inaccurate, her account as it pertained to core matters was broadly coherent and consistent throughout the trial.

The letter of complaint and Dr Spittle's response: no allegation of sexual abuse

[35] The second issue raised by Mr Waalkens on appeal related to the 1999 letter of complaint, namely that:

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[6] Dr Spittle said this was a typographical error — that he intended to refer to "self-disclosure: [being a] technique whereby one shares something of one's life [rather than] self-discovery".

(a) there is no mention of sexual touching in the 1999 letter of complaint and there was no logical reason for leaving it out, as she was no longer under Dr Spittle's supervision at the time of the letter; and

(b) Dr Spittle's response in the letter was entirely consistent with his evidence — he tried too hard to form a therapeutic connection with W because W's mental health issues mirrored his son's condition.

Assessment

[36] The letter of complaint does not mention sexual touching and we accept that Dr Spittle did not resile from the position he had taken in his response to the letter in 1999. There is also strongly supportive contemporaneous observational and character evidence which suggested that while Dr Spittle took a slightly unorthodox approach to all his clients — he was professional, attentive and empathetic to his clients. As noted, the medical records do not corroborate some of the key claims made by W about inappropriate hand-holding. These are defence factors to be weighed in the evaluative assessment.

[37] But the letter and Dr Spittle's response provide important contemporaneous circumstantial evidence supporting W's broader narrative. Relevantly, W's complaint records a number of allegations, accepted in part by Dr Spittle in his response, including:

(a) An acknowledgement that:

> It was wrong … for me to become so involved and to think that I could connect with her when others had not. I fell into a trap that I should not, with all my years of experience, have fallen into.

(b) An observation he put the tip of his finger lightly on the side of her knee:

> … trying to connect with her to show that I cared, to help her trust me so that I could help her as a person who was fragile and unhappy. I appreciate that the use of touch in therapy is controversial and this is not something that I have done before.

(c) He said:

> I have not attempted such self discovery with patients previously, though I have read about this as a means of gaining trust in a therapeutic relationship. Now that I analyse the situation, this is clearly not an appropriate disclosure to make.

(d) He stated:

> I did not maintain professional detachment, thinking if I cared more – gave more – she could be saved. This was wrong of me.

(e) And further:

> I reject any implication of an abuse of power and assure you that there was no sexual component in my feelings for this patient … When reviewing the situation in retrospect, I accept that I made errors of judgment which I find it difficult to forgive myself for. I apologise for the distress this caused.
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> …
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> I have let my colleagues, my family, my wife and myself down.

[38] In addition, Dr Spittle did not come through cross-examination unscathed. First, he conceded under cross-examination (as he had done in his response statement) that a number of the facts asserted by W were correct, including her claims of inappropriate (but not sexual) touching and unprofessional dealings with her. Second, his evidence about the closeness of his relationship with W may have appeared unconvincing to the jury. For example, Dr Spittle explained that the purpose of his frequent and at times lengthy sessions with W (employing among other things "touch in therapy") was to develop a therapeutic connection. But Dr Spittle also conceded that it was not his role and he was not engaged in providing therapy. While Dr Mason (a registered psychiatrist) suggested in subsequent defence evidence that the use of therapeutic techniques for assessment purposes was not necessarily inappropriate, the jury, reasonably, may have doubted this explanation for an otherwise unprofessionally close relationship with a patient suffering from among other things BPD.

[39] Third, Dr Spittle's at times lengthy evidence also appeared to lapse into advocacy under cross-examination. For example, he took the opportunity (at some

considerable length) to explain how persons with BPD may develop false ideas about their doctors, noting cases of false accusations of sexual violation against medical professionals. Rather than enhancing the jury's view of Dr Spittle, all of this may have legitimately carried an air of undue defensiveness, undermining his credibility.

[40] Fourth, W's explanations (noted at [16] above) for not raising the allegations of sexual touching at the time of the offending are entirely consistent with expert treatment of counter-intuitive evidence, as described by Dr Blackwell.

[41] In the result, while the letter of complaint and reply were not directly corroborative of sexual touching having taken place, this material was relevant contemporaneous circumstantial evidence largely supporting the complainant's evidence of an inappropriate unprofessional relationship. It also legitimately exposed Dr Spittle to questioning about his behaviour toward W.[7] We therefore reject this ground as providing an independent basis for revisiting the jury verdict.

W's mental health

[42] Mr Waalkens made two primary submissions on the issue of W's mental health:

(a) W was suffering a constellation of mental health issues, including BDP and dissociation, such that there was a high risk of misinterpretation and misunderstanding of Dr Spittle's actions or filling gaps in memory with things she believed to be consistent with reality, for example, that Dr Spittle was in love with her; and

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[7] The Judge warned the jury when summing up that it could not use the letter "as an indication or inference of doing anything more serious, such as what is now alleged" because the allegations at trial did not form part of the 1999 complaint and that the jury could not "use anything in the letter that amounts to acceptance of any such conduct". We think that the first part of the direction was unduly cautious. The letter and response formed part of the circumstantial evidence relevant to assessing, among other things, the cogency and credibility of the complainant's account at trial and Dr Spittle's narrative of what he said occurred. In any event, the letter and response corroborated key components of W's account.

(b) this is not a case where the delay in bringing a complaint is explained by counter-intuitive evidence because W did complain about Dr Spittle in 1999, but without reference to sexual touching, while at the same time referring to unwanted touching by other unidentified males.

Assessment

[43] Dr Blackwell's evidence provided a sufficient and proper basis for the jury to reject the reliability challenge to W's evidence based on her mental health disorders. Dr Blackwell rejected the proposition that a person with BPD, a generalised anxiety disorder, recurrent depressive episodes and eating disorder, as a combination of issues, has "all the risks and hallmarks of [affecting] reliability and memory". It was open to the jury to accept this evidence. Dr Goodwin's contrary opinion about the potential risks of suggestibility, transference and recovered memories, was cogently made. Nevertheless his evidence on this topic was not so compelling as to make a contrary finding unreasonable.

[44] As to Mr Waalkens' second point, it was open to the jury to conclude that Dr Blackwell's evidence did assist them in understanding W's conduct in relation to the complaint to Dr Holdaway. While it is true that she made only a limited complaint to Dr Holdaway, she explained her failure to complain about the sexual touching, referring to her shame and embarrassment about what had occurred and her own feelings of responsibility. Under cross-examination she said further:

> I didn't have the emotional capacity, I was just barely hanging on to surviving at that point. All I wanted, and I made it very clear to her and I said yesterday, all I wanted was that, um, that [Dr Spittle] didn't have any contact with me, that was my main aim in seeing her.

Effect of counselling / "false complaints"

[45] The final key issue underlying the appeal was the effect counselling may have had on W. Mr Waalkens submitted:

(a) W made "false complaints" against her father and a person called Brian, evincing a capacity to generate false memories or allegations while under counselling; and

(b) W has a high risk of suggestibility, and since the time of the alleged offending (in 1999) has been subject to continuous years of intensive counselling, including about sexual abuse, out of which emerged fresh false "flashbacks" of sexual abuse.

Assessment

[46] There was evidence that W had previously suggested in counselling that she may have been sexually abused by her father:

> Q. And just tell us, what was it that you or what were the circumstances where you felt you may have been sexually abused by your father?
>
> A. Um, I had been asked repeatedly by just about every counsellor I had worked with, like whether I had been sexually abused and like I had got the impression that my symptoms would be more understandable had I been sexually abused, um, and I was trying to think, "Is this what's happened?" or "Is this not what's happened?" um, I also said to the counsellor in the end that I thought that I hadn't been.

[47] There is also a record in counselling notes referring to a worker named Brian having "started stroking, grabbing [her] breast around [her] stomach". In addition, there is no dispute that W received extensive counselling in the period 1999 to 2012, including enquiry into whether she had been sexually abused. It is also clear that the present allegations coincided with an incident of indecent photography involving a young person known to W. W also gave evidence that the counselling and this event triggered her memories of what she said Dr Spittle did to her.

[48] Dr Goodwin then gave expert medical evidence that there is good research which suggests questioning from people in position of authority can more easily suggest to people that things have happened. He expressed extreme caution and scepticism about the reliability of recovered memories. The delay and the staccato nature of the unveiling of W's complaint (she did not mention the ice-skating

incident in her first interview) also adds weight to concerns about the reliability of W's post-counselling allegations.

[49] Against this, it is evident that the references to sexual abuse by her father never crystallised into a formal complaint, notwithstanding pressure to identify abuse, and W did not accept that the note about Brian was an accurate record of what she said. Rather she said that she wasn't sure it was "intentional or just in the course of work". In our view the so called "false complaint" evidence falls well short of demonstrating a propensity to make false complaints during counselling and it was available to the jury to place little or no significance on it.

[50] As to false flashbacks, the potential for false memories was and is a highly contestable matter. As noted by Dr Blackwell, a survey of relevant psychological literature suggests people may recover or recall memories or traumatic events, such as sexual abuse, after a long period of time during which they have partially or completely lost access to those memories. Dr Blackwell considered the opinion that BPD patients are more susceptible to contamination of memory was a generalisation and stated that there is no empirical evidence to suggest sufferers are more susceptible to contamination.

[51] Accordingly, we consider that the jury had a proper and sufficient basis to reject the defence case based on the effect of counselling, contamination, suggestibility and false memories.

Overall assessment

[52] We have reviewed the evidence in light of the arguments presented by Mr Waalkens. We accept that the matters raised have a proper basis and were legitimately left with the jury. But as with many cases of this nature, the central issue for the jury to resolve was whether the complainant was both credible and reliable. We find that the jury had a sufficient and proper basis to prefer W's account. It was clearly evident that Dr Spittle developed an unprofessionally close relationship with W and that he regularly touched her. With these facts established, it was open to the jury to prefer W's coherent and internally consistent evidence,

particularly in light of Dr Blackwell's expert evidence, to that of Dr Spittle and his expert. Countervailing evidence, including a lack of corroborative notes on ancillary matters such as complaints about hand-holding, was not of such a nature or scale as to render the balance of W's evidence unreliable or lacking credibility.

[53] Overall the matters raised by Mr Waalkens were properly put to the jury but it was plainly open to them to find that W's evidence was both credible and reliable.

Outcome

[54] We are not satisfied that, having regard to all the evidence, the jury could not reasonably have concluded to the required standard that Dr Spittle is guilty. The appeal is dismissed.

Solicitors:
DLA Piper New Zealand, Auckland for Appellant
Crown Law Office, Wellington for Respondent