Virtual Section 29 Case Meeting

19 February 2021

[redacted]

Members present
Tom Frawley (in the Chair), Board Member, Professional Standards Authority
Mark Stobbs, Head of Scrutiny & Quality, Professional Standards Authority
Simon Wiklund, Head of Legal, Professional Standards Authority

In attendance
Michael Standing**,** Counsel, 39 Essex Chambers, Legal Advisor

Observers
Caroline Corby, Chair, Professional Standards Authority
Remi Gberbo, Solicitor, Professional Standards Authority
Briony Alcraft, Scrutiny Team Co-ordinator, Professional Standards Authority
Dan Scott, Accreditation Officer, Professional Standards Authority

1. Definitions

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the Authority, together with any abbreviations used specifically for this case are set out in the table at Annex A.

2. Purpose of this note

2.1 This meeting note records a summary of the Members' consideration of the relevant decision about the Registrant made by the regulator's panel, and the Authority's decision whether or not to refer the case to the court under Section 29 of the Act. The meeting was held virtually.

3. The Authority's powers of referral under Section 29 of the Act

3.1 The Authority may refer a case to the relevant court if it considers that a relevant decision (a finding, a penalty or both) is not sufficient for the protection of the public.

3.2 Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:

- to protect the health, safety and well-being of the public
- to maintain public confidence in the profession concerned, and

- to maintain proper professional standards and conduct for members of that profession.

3.3 This will also involve consideration of whether the panel's decision was one that a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could not reasonably have reached; or was otherwise manifestly inappropriate having regard to the safety of the public and the reputation of the profession (applying *Ruscillo*[1]).

4. Conflicts of interest

4.1 The Members did not have any conflicts of interest.

5. Jurisdiction

5.1 The Legal Advisor confirmed that the Authority had jurisdiction to consider the case under Section 29 of the Act. Any referral in this case would be to the High Court of Justice of England and Wales and the statutory time limit for an appeal would expire on 26 February 2021.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a substantive meeting of the NMC's Fitness to Practise Committee which concluded on [redacted]

6.2 The Panel's Determination which includes the charges and findings is set out at Annex B.

7. Documents before the meeting

7.1 The following documents were available to the Members:

- Determination of the panel dated [redacted]
- The Authority's Detailed Case Review
- Transcripts of the hearing dated [redacted]
- Counsel's Note dated 18 February 2021
- NMC Case Examiner Bundle and decision letter
- CCTV stills
- Key documents from the NMC evidence bundle
- The NMC's Code – effective from March 2015
- The NMC's Indicative Sanctions Guidance – July 2017

[1] CRHP v Ruscillo [2004] EWCA Civ 1356

- The Authority's Section 29 Case Meeting Manual.

7.2 The Members and the Legal Advisor were provided with a copy of a response from the NMC to the Authority's Notification of Section 29 Meeting.

8. Background

8.1 The Registrant was employed as a Band 7 Charge Nurse in the Emergency Department of a hospital at the time of the events.

8.2 Complaints were made to members of the senior leadership team about the Registrant's conduct during the night shift on 23/24 February 2018, which formed the basis of the allegations. These involved the Registrant shouting at colleagues and ambulance service staff, shouting at a distressed member of a patient's family, complaining loudly about a distressed member of a patient's family, stating to a junior colleague, 'I can't understand a word you are saying' before hanging up, failing to attend a multi-disciplinary hand over from the day-shift without reason, and unnecessarily demanding a colleague returned early from her break to carry out a patient transfer.

8.3 The Registrant attended an informal meeting with the Matron of the department on 12 March 2018 to discuss the concerns raised and was offered support, including access to leadership training and occupational health support.

8.4 Further complaints were received about the Registrant's inappropriate communication with team members in mid-April, and on 30 April 2018, he was put on an informal improvement notice.

8.5 On 11 August 2018 a complaint was made regarding the Registrant's treatment of an intoxicated patient brought by ambulance to the A&E Department. The Registrant had used a bedsheet to tie Patient A to a wheelchair and had placed a cardboard commode liner secured with elastic under the Patient's chin and neck and placed a clinical waste bag over and around his neck securing it under the commode liner.

8.6 Following a local investigation, the Registrant was suspended, and at a disciplinary hearing on 22 February 2019 he was dismissed with immediate effect for gross misconduct.

8.7 All of the allegations were admitted by the Registrant, who did not attend the hearing (Substantive Meetings are held in private), although CCTV footage, documentary evidence and submissions, were before the Panel.

8.8 The Panel found impairment on public protection and public interest grounds and imposed a Conditions of Practice Order for 12 months.

9. Applying Section 29 of the 2002 Act

9.1 The Members considered all the documents before them and received legal advice.

9.2 The Members discussed the following concerns about the decision:

Under-prosecution

9.3 The Members first discussed their concern as to whether all the relevant evidence of the Registrant's aggressive and intimidating behaviour towards colleagues was encapsulated within charges 1 and 2.

9.4 The Members noted that a failure to communicate appropriately could be interpreted fairly broadly, and although the charges did include aspects of inappropriate communication, several other communication issues involving unprofessional, confrontational and aggressive behaviour towards staff, patients and family members, (which had been alleged in witness statements) had not been expressly charged by the NMC. The Members felt that although it was not necessary for each and every incident to have been charged, the Registrant's behaviour raised concerns about potential attitudinal failings which were not fully captured by the charges.

9.5 The Members considered that at least two of the allegations raised in a witness statement from a colleague alleged attitudinal failings, for which there was sufficient supporting evidence, and which were, in the Members' view, without doubt breaches of the Code which may well have reached the threshold of misconduct. The Members therefore considered that these should have formed the basis of separate charges. They considered that without these charges the Registrant's bullying and intimidating behaviour and approach to patients had not been fully addressed by the Panel.

9.6 In addition, the Members noted that the NMC did not appear to gather any evidence regarding the impact of the Registrant's [redacted] on his behaviour, and consequently there were no charges alleging impairment [redacted]. The Members noted that [redacted]

9.7 The Members noted that the Registrant was [redacted], but that due to the NMC's lack of investigation into this area, it was difficult to reach a conclusion on whether this was warranted, especially when bearing in mind his previous 16 years of professional practice where no related concerns have arisen.

The Panel's evaluation of the evidence

9.8 The Members next considered whether the Panel had adequately addressed the gravity of the misconduct in reaching its decision on misconduct. They noted that the case had been considered at a substantive meeting, so the Members did not have the benefit of a transcript of the Panel discussion. However, they noted specifically that despite the stark evidence in the witness statements, the Panel's analysis of the misconduct was brief and no direct

reference was made to the extent to which Patient A's dignity was compromised by the Registrant's actions, (though the Members did note that the Panel did refer to breaches of the NMC code in respect of upholding dignity).

9.9 The Members were concerned to note that the NMC's presentation of the evidence regarding the inappropriate treatment of Patient A appears to have been replicated by the Panel almost verbatim, leading them to believe that despite the Panel having access to the evidence regarding the full extent of the Registrant's behaviour, it might not have turned its mind to this wider evidence and undertaken a proper assessment of the extent and seriousness of the concerns, specifically noting that the Panel did not expressly refer to any incidents other than those which formed the substance of the charges.

9.10 The Members noted that similar concerns arose in the NMC's written statement of case regarding the evidence in relation to the Registrant's behaviour towards colleagues, in that the findings are taken almost verbatim from the NMC submissions, making it difficult for the Members to assess whether the Panel had evaluated, and thus appreciated, the seriousness and potential bullying aspect of the Registrant's behaviour.

9.11 The Members therefore concluded that the Panel had not sufficiently examined the seriousness of the concerns in relation to upholding public confidence and standards of behaviour in the profession. As a consequence, they may have failed to reach a sanction that was sufficiently robust and proportionate in this case.

9.12 Importantly, the Members did not consider that this was a suitable case for consideration at a Substantive Meeting given the extent of the concerns raised, and that the NMC should have listed the case for a Full Hearing for a Panel to hear direct evidence from the Registrant .

The Panel's assessment of aggravating and mitigating factors

9.13 The Members discussed the Panel's approach to the aggravating and mitigating factors, noting that aggravating factors were the same as those submitted by the NMC, which, again, led the Members to wonder whether there was sufficient independent assessment and analysis by the Panel.

9.14 They considered that the Panel had not identified a number of factors which aggravated the seriousness of the misconduct: the sheer inappropriateness of the Registrant's actions in respect of Patient A and his failure to respect the patient's dignity and basic human rights. In addition, the Members noted that no mention was made of the Registrant's failure to engage with attempts to address concerns at a local level, the fact that further concerns were raised about his conduct following the initial complaint being drawn to his attention, or the impact of his behaviour on his colleagues.

9.15 The Members considered these were crucial factors the panel should have expressly considered when looking at public interest aspects of the case and in looking at sanction.

9.16 The Members considered the mitigating factors to be weak and that it was questionable whether a Registrant's admissions could be regarded as 'mitigation'. Further, they found it impossible to gauge which factors the Panel

considered should be afforded particular weight in its conclusion that conditions should be imposed.

Serious attitudinal failings

9.17 The Members discussed the Panel's finding that there was no evidence of harmful deep seated personality or attitudinal problems, which they considered to be curious, given the obvious concerns around the Registrant's attitude and his previous failures to engage with support at a local level. It was not clear to the Members if the [redacted] had had a bearing on this finding, but the Members considered it strengthened the argument about the Panel's skewed approach to sanction.

Did the conditions address the failings?

9.18 Notwithstanding its view that the Panel should have given more careful consideration to whether an order for suspension was more appropriate, the Members next discussed whether the conditions meaningfully addressed the concerns identified.

9.19 They noted that a condition relating to [redacted] had been imposed, but queried the basis for this given that there were no charges relating to [redacted]. Further, the Members considered it appeared the Registrant was out of his depth whilst acting as a Nurse in Charge but noted that none of the conditions restrict the type of roles in which he should seek employment or required him to undertake any leadership and/or management training before being permitted to work at that level. The Members also had some concerns about the 'indirect supervision' which could in essence only be in place for a limited period.

9.20 However, they also noted that the courts would give deference to the Panel's views. They noted that, for example, the extracts from the CCTV evidence did not suggest that the Registrant was acting maliciously, that there was no physical harm to the patient and that there was clear evidence that the Registrant was generally a caring nurse. They considered that the condition requiring the Registrant to work with his line manager to create a personal development plan designed to address his development of communication skills and the appropriate use of restraint does in fact go some way towards addressing the failings identified. In addition, the conditions would be reviewed and the Registrant's progress monitored.

Conclusion on insufficiency for public protection

9.21 In light of their concerns, the Members concluded that the NMCs failure to include charges in relation to the Registrant's bullying and intimidating behaviour and approach to patients, and the Panel's consequent failure to sufficiently examine the seriousness of the concerns in relation to upholding standards of behaviour in the profession and public confidence in the profession, was a serious procedural irregularity which meant the Members were unable to determine whether the outcome of the case was insufficient.[2] However, had those matters been properly presented, proved and addressed, it was likely that suspension would have been an appropriate and proportionate

[2] *Ruscillo* at [72]

sanction, rather than the sanction of conditions of practice which the Panel decided to apply.

10. Referral to court

10.1 Having concluded that the panel's Determination was insufficient for public protection, the Members moved on to consider whether they should exercise the Authority's discretion to refer this case to the relevant court.

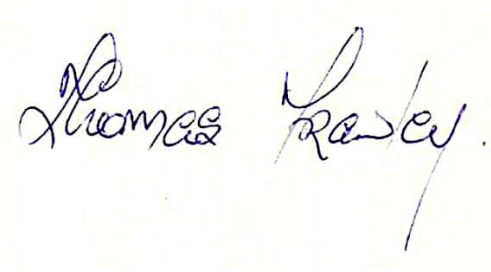
10.2 In considering the exercise of the Authority's discretion, the Members received legal advice as to the prospects of success and took into account the need to use the Authority's resources proportionately and in the public interest.

10.3 The Members concluded that this was a finely balanced decision where the conditions, which will be subject to a review, do provide a measure of public protection and do send a signal that the Registrant's conduct was not acceptable. The Members also took into account that this was not a case where the conduct took place behind closed doors and did not appear malicious, and therefore could not conclude that the imposition of conditions was so wrong that an Authority appeal was required in order to protect the public.

10.4 Taking into account those considerations, along with advice on the prospects of success, the Members agreed that the Authority should not exercise its power under Section 29 and refer this case to the High Court of Justice of England and Wales.

11. Learning points

11.1 The Members agreed that the learning points set out at Appendix C should be communicated to the Regulator.



12/05/21

Tom Frawley (Chair) **Dated**

12. Annex A – Definitions

12.1 In this note the following definitions and abbreviations will apply:

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	A Fitness to Practise Committee of the NMC
The Registrant	[redacted]
The Regulator	The Nursing and Midwifery Council
Regulator's abbreviation	NMC
The Act	The National Health Service Reform and Health Care Professions Act 2002 as amended
The Members	The Authority as constituted for this Section 29 case meeting
The Determination	The Determination of the Panel sitting on [redacted] 2020
The Court	The High Court of Justice of England and Wales
The Code	NMC Code of Conduct in force at time of incident - March 2015
The SG/ISG	NMC Indicative Sanctions Guidance in force at sanction stage - July 2017