Section 29 Case Meeting

25 January 2023

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

David LIMBO

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Christine Braithwaite, Director of Standards & Policy, Professional Standards Authority
Simon Wiklund, Head of Legal, Professional Standards Authority

In attendance
David Hopkins, Counsel, 39 Essex Chambers

Observers
Dami Olatuyi, Accreditation Officer, Professional Standards Authority
Juliet Oliver, Board Member, Professional Standards Authority
Michael Humphreys, Scrutiny Manager, Professional Standards Authority
Rachael Martin, Scrutiny Team Coordinator, Professional Standards Authority
Graham Mockler, Assistant Director Scrutiny & Quality, Professional Standards Authority

This meeting was held remotely

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.

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 27 January 2023.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 24 November 2022.

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 24 November 2022
- The Authority's Detailed Case Review
- Counsel's Note dated 23 January 2023
- Case Examiners' Masters bundle
- Exhibits
- Substantive meeting bundle
- The NMC's Sanctions Guidance
- The Authority's Section 29 Case Meeting Manual.

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

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. The Members considered the response having received legal advice and after they reached a conclusion on the sufficiency on the outcome.

8. Background

8.1 The Registrant was employed as a registered nurse at the material time.

8.2 The allegations were considered at a substantive meeting held in private and on the papers only; no transcripts were produced. The Registrant did not submit any evidence for the meeting.

8.3 The allegations concerned the Registrant's conviction on indictment at Woolwich Crown Court on 12 March 2018 on a guilty plea of controlling or coercive behaviour in an intimate or family relationship. He was sentenced to a 12-month community order to carry out 80 hours of unpaid work and ordered to pay a victim surcharge of £85.00.

8.4 The Registrant had originally pleaded guilty to the offence at a trial listed on 12 March 2018. The case was subsequently adjourned for sentencing but when it was listed, the Registrant indicated that he wished to withdraw his plea. He later informed the court that he no longer wished to pursue the application to vacate his guilty plea.

8.5 The Registrant had originally notified the NMC by way of self-referral on 21 August 2016 that he had been charged with sexual assault, Actual Bodily Harm and assault.

8.6 On 17 January 2019, the Case Examiners were invited to consider the regulatory concern described as, '*failure to abide by the law*'. They concluded that the Registrant did not have a case to answer because there was no realistic prospect of a Panel finding current impairment.

8.7 An internal review of the Case Examiners' decision was conducted, and an Assistant Registrar reviewed the decision pursuant to Rule 7A on 29 March 2022 on the basis that the Case Examiners' decision that the Registrant had no case to answer was materially flawed.

8.8 The review decision confirmed that in a letter dated 7 January 2019, the NMC had been notified of a decision made by the Disclosure and Barring Service (DBS) that the Registrant be included on the Children's List and Adults List as of 2 January 2019. The DBS' letter had been uploaded to the NMC's database however it was not included in the evidence put before the Case Examiners.

8.9 The Assistant Registrar had directed that the DBS be contacted for a summary of the reasons for the Registrant's inclusion in the barring list before making their final decision, but no request had been received in response to the request.

8.10 The Assistant Registrar's review concluded there was a material flaw in the decision that there was no case to answer as relevant information (the DBS notification) was not put before the Case Examiners and the Case Examiners had failed to give adequate reasons.

8.11 It was therefore determined given the information provided by DBS that there was a realistic prospect of a finding of impairment being made on public protection grounds and that regulatory action was needed to uphold public trust in nurses. The case was therefore referred to an FtP meeting for consideration.

8.12 At that meeting a Panel found that the Registrant's fitness to practice impaired by reason of the conviction and imposed a suspension order for 9 months with a review hearing to be held.

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:

The NMC's investigation & relevant evidence

9.3 The Members were mindful that the reasons for the Registrant's inclusion on the DBS barred lists for children and adults are not known. The Members considered whether the NMC had failed to fully investigate why the Registrant was included on the DBS lists and additionally whether the Panel had failed to inquire adequately into this issue.

9.4 It was clear that the NMC had made some initial enquires regarding the Registrant's inclusion on DBS lists but there was a failure to follow-up following a lack of response from the DBS. Nor was it apparent that the NMC had used its statutory powers to require disclosure of the reasons for the Registrant's inclusion on the DBS lists.

9.5 The Members concluded that the Panel did not have all the relevant material it needed in front of them to make an informed decision given that there was nothing before them to confirm the circumstances which led to the Registrant's inclusion on both of the DBS lists, particularly given the victim in the case was an adult. The Registrant's inclusion on the lists was an aggravating factor, and the Panel in their conclusions, placed weight on the Court conviction without separately weighing any potential reasons for the Registrant's inclusion on the lists and the seriousness this posed.

9.6 The Members considered that the Panel also failed to make enquiries to satisfy itself that it had sufficient evidence on which to base a decision about regulatory action. As a Panel of inquiry, it would be expected to have asked questions regarding the Registrant's inclusion on the lists. While the Registrant's inclusion on the lists precludes him from working with adults and children this was not enough in terms of reassurance and the Panel were required to know details to understand why the DBS considered the Registrant posed a risk. The Members felt this information was highly material to a Panel's assessment of public interest engaged in the case and the sanction decision.

9.7 The Members also considered that that it was open to them and anyone reading the decision to suppose that the Panel assumed that the Registrant's inclusion on the lists was in relation to the conviction. If this was the case, it was wrong

for the Panel to have done so as there appeared to be no evidential basis for this assumption.

9.8 The Members concluded that the fact that the Registrant had been placed on the lists was material to the Panel's consideration of seriousness. In the absence of any evidence confirming why he was placed on the lists it was not for the Panel to make any assumptions. With that in mind, the Panel should have considered adjourning or making further inquiries and its failure to do so was a serious procedural irregularity because it meant it was not possible to say whether the outcome was sufficient for the protection of the public.

Impairment & public confidence

9.9 The Members considered whether the Panel gave adequate consideration to the impact on public confidence arising from the Registrant's conviction and significantly, the Registrant's inclusion on the DBS lists.

9.10 The Panel in determining that an order for suspension was appropriate and proportionate, appeared to have placed undue weight on the sentencing Judge's view that the Registrant's actions were not at the most serious end of the spectrum. While this was relevant to the Judge's function in determining the criminal sentence for the offence, it was of lesser relevance to the Panel's role as regards to the overarching objective of public protection.

9.11 The Members acknowledged that being on DBS barred lists did effectively stop the Registrant from being able to practice and indeed the Registrant described himself as unemployable as a result of his DBS inclusion. In this respect the effect was similar to being suspended from the NMC's register but it was still open to the Registrant to apply to come off the barred lists.

9.12 The Members concluded that the Panel had failed to fully grapple with the seriousness of the conviction. The case involved behaviour not conducive to working in a caring profession. The Members concluded that this was the basis on which the Panel should have considered the case and not on the fact that the Registrant did not receive a custodial sentence.

The Panel's application of the Sanctions Guidance

9.13 The Members considered whether the Panel properly applied the SG in terms of seriousness.

9.14 The Panel had identified a risk of repetition, had found that the Registrant had demonstrated no insight and considered that there was evidence of underlying attitudinal concerns although the Panel appeared to attach lesser weight to this as it did not relate to his clinical practice.

9.15 The Members considered whether the Registrant's clinical practice was a relevant factor given the circumstances of the conviction and whether in placing weight on this, the Panel had misdirected itself. The Members identified the apparent linking of attitudinal failings to clinical practice as being an error of approach. The Members did not consider that any attitudinal failings had to relate to clinical practice in order to be relevant and referred to the example of dishonesty.

9.16 The Members were also concerned by the weight given by the Panel to the sentence imposed in relation to conviction. The Members noted that the purpose of criminal proceedings was different to that of regulatory proceedings and obviously the sentence imposed is relevant. Yet the Panel here, appear to have placed weight on the fact that a non-custodial sentence was imposed, and this appears to have had some impact on the sanction decision. Although this was a relevant factor, the Members felt the Panel possibly placed too much weight on this rather than consider what was important in the fitness to practise context and specifically what was necessary to maintain public confidence.

9.17 In this case, in terms of the SG the factors relevant to a suspension, attitudinal failings and a lack of insight were clearly engaged. The Registrant was identified as displaying attitudinal failings through his refusal to accept the outcome of the criminal proceedings and showing no insight. By then stating that these factors did not relate to his practice, the Panel in effect downplayed their seriousness which the Members considered to be an error. Furthermore, there was no evidence to suggest that the Registrant could or would develop the necessary insight. The Members were concerned by the Panel's decision to afford the Registrant an opportunity to develop insight given the lack of evidence to suggest that he would take this opportunity and this approach has previously been criticised by the Court in other cases. The Members concluded that this was essentially wishful thinking on the Panel's part without foundation and it was not the Panel nor NMC's role to provide such opportunities to registrants but to protect the public.

9.18 The Members concluded that the Panel departed from the SG in the failure to provide any reasons to suggest why it would be appropriate to afford the Registrant an opportunity to develop insight. Furthermore, the Members felt that the Panel misdirected itself in concluding that attitudinal failings needed to relate to a Registrant's clinical practice. In addition, the SG states that attitudinal problems are difficult to address, and a high degree of insight and remorse was expected to be able to continue to practise, neither of which were present in this case.

Fundamental incompatibility

9.19 The Members considered whether the Panel had provided an explanation as to why it considered the Registrant's actions not to be fundamentally incompatible with continued Registration.

9.20 The Members noted that nursing comprises the elements of care, compassion and conduct in addition to competence and the Panel failed to recognise or acknowledge that the Registrant's conviction was in complete contrast to these elements. The Members considered that the Registrant's lack of insight and attempts to undermine the conviction pushed this case into the category where only removal could adequately protect the public. The Members considered that the Panel erred in its assessment that the Registrant's conviction was not fundamentally incompatible with continued registration.

9.21 The Members also struggled to understand how the Panel found that the Registrant had breached a fundamental tenant of the profession yet concluded without justification that this was not incompatible with remaining on the

register. The Panel was required to give more adequate reasons for why it found the conviction not fundamentally incompatible with continued registration.

Conclusion on insufficiency for public protection

9.22 The Members concluded that the Panel's decision to suspend the Registrant was insufficient for public protection in a number of respects.

9.23 Both the NMC and the Panel failed to fully investigate and inquire as to the reason why the Registrant was placed on the DBS lists. This resulted in the Panel not having all relevant material before it and failing to give proper consideration to public interest at the sanction stage. It was not clear to Members whether the Panel (and the NMC) had made assumptions as to why the Registrant was on the DBS lists. There was an expectation from the public that the Panel would undertake more than a superficial inquiry and take appropriate action. It was clear to Members that the NMC should have obtained further information, or the Panel should have adjourned the proceedings so that further information could be obtained.

9.24 In light of their concerns, the Members concluded that the NMC and Panel's failure was a serious procedural irregularity which meant the Members were unable to determine whether the outcome of the case was sufficient for the protection of the public.[2]

10. Referral to court

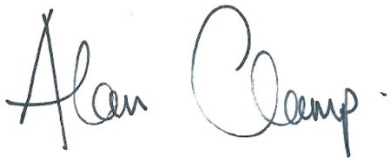
10.1 Having concluded that the Panel's Determination was insufficient for public protection, the Members moved on to consider whether they should exercise the Authority's discretion to refer this case to the relevant court.

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 considered the potential impact on the Registrant of any referral to the High Court but concluded that the need to protect the public outweighed the interests of the Registrant. The Members also considered whether public protection could be secured by alternative means but concluded that it could not.

10.4 Taking into account those considerations, along with advice on the prospects of success, the Members agreed that the Authority should exercise its power under Section 29 and refer this case to the High Court of Justice of England and Wales.

[2] *Ruscillo* at [72]



13/04/23

Alan Clamp (Chair) **Date**

11. Annex A – Definitions

11.1 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	David Limbo
The Regulator	The NMC
NMC	Nursing & Midwifery Council
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 24 November 2023
The Court	The High Court of Justice of England and Wales
The SG	Regulator's Sanctions Guidance