Section 29 Case Meeting

16 April 2021

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

[redacted]

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Mark Stobbs, Director of Scrutiny & Quality, Professional Standards Authority
Graham Mockler, Assistant Director of Scrutiny & Quality (Performance), Professional Standards Authority

In attendance
Christine O'Neill, Solicitor, Legal Advisor, Brodies LLP Solicitors

Observers
Douglas Waddell, Senior Solicitor, Brodie LLP Solicitors
Rachael Martin, Team Coordinator, Professional Standards Authority
Marcus Longley, Board Member, 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.

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 Court of Session and the statutory time limit for an appeal would expire on 23 April 2021.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing 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]
- Legal report by Brodies Solicitors dated 15 April 2021
- Exhibits
- CE Decision letter to Registrant
- CE Masters
- Final hearing decision letter to Registrant
- The NMC's Indicative 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 s.29 Meeting.

8. Background

8.1 The misconduct in this case arises from the Registrant's employment as a registered nurse at a residential home. The Registrant had worked at the home since [redacted] as a general staff nurse, being responsible for administering medication and supervision of care assistants.

8.2 Whilst on shift as the nurse in charge on [redacted] the Registrant was alleged to have witnessed the abuse of Resident A, a 98-year-old lady with dementia. Resident A was dragged backwards on a chair by Colleague A, a care assistant at the home. The incident was not reported or escalated, and a second similar incident of abuse towards Registrant A occurred days later.

8.3 The first incident was reported to the home manager, on [redacted]. He questioned why the incident had not been reported sooner. An investigation commenced and two carers stated that the Registrant had been present and witnessed the event and did not intervene. Both stated that they did not report the incident as they assumed that the Registrant would do so being the most senior member of staff on duty.

8.4 The Registrant was interviewed twice on the same day and denied all knowledge of the incident. The home would later go on to conclude that they did not believe she was being truthful and disciplinary proceedings against her were commenced. She resigned days later.

8.5 The NMC's case focused on the failure to intervene and record and report the incident. There was no charge of lack of integrity/candour or dishonesty in relation to the denials and no charges which went to motivation. The Registrant did not attend the hearing but did provide a reflective statement which demonstrated limited insight.

8.6 The factual allegations were found proven and the Panel found misconduct and impairment on both the personal and public components. The NMC argued that the registrant should be struck off. The panel imposed a 9-month suspension with a review.

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

Registrant's motives

9.3 The Members firstly considered the issue of motivation given that the evidence in the bundles presented to the Panel suggested that the Registrant had a friendship with Colleague A outside of work. The Members considered however, that there was insufficient evidence to enable a panel to find this proved as a motive for her behaviour.

Candour

9.4 The Members noted that whilst there was no separate allegation of a breach of the duty of candour, this was probably sufficiently captured in the allegation of failing to report and would not have added anything further to the allegations.

9.5 The Members also considered the failure to allege dishonesty. The Members noted that the Registrant denied witnessing the incident yet there were witnesses who claimed that she was in the room at the time of the incident and therefore witnessed it. The Members were not satisfied that the Registrant's denial of witnessing the incident which she reported was implicit in the allegations charged and in particular the allegation of failing to report. The members also felt that given the Registrant's denial of witnessing the incident which the Panel went on to find proved, the possibility of attitudinal problems should have been further explored by the Panel.

9.6 The Members concluded that there had been a failure to allege dishonesty in this case, but they were not satisfied that based on the evidence that the panel would inevitably have found dishonesty or that this would necessarily have required the registrant to be struck off.

Aggravating Factors

Sanction

9.7 The Members considered whether the Panel had given adequate regard to the aggravating and mitigating factors and provided sufficient reasons for its decision at the sanction stage.

9.8 The Members were concerned that the Panel did not consider actual harm caused to Resident A as a result of Colleague A's conduct. Furthermore, the Panel failed to give adequate consideration to the Registrant's denial of the allegations which they found proved, yet the Panel found it a mitigating factor that the Registrant made an admission to charge 1(b) which the Panel found not proved. Furthermore, the other allegations admitted by the Registrant were noted by the Panel as factual and it was therefore questionable as to whether these admissions should have been considered as mitigation by the Panel.

9.9 The Members were concerned that the Panel did not appear to have adequately considered the fact that they made findings which the Registrant denied may have indicated a lack of insight.

9.10 The Members considered, however, that the Panel had given appropriate weight to the factors set out in the NMC's ISG indicating suspension and that

this was a case which met those criteria. However, the Members felt that the Panel's discussion of the reasons why it did not impose a removal order were sparse and the Panel did not give adequate consideration at this stage to the Registrant's lack of candour and dishonesty.

Conclusion on insufficiency for public protection

9.11 The Members were concerned about the Panel's failure to explore dishonesty more and that with the sparse reasons for not imposing a harsher sanction. Nevertheless, the Members were not convinced that, had it done so, it would have concluded that removal from the register was required.

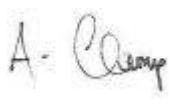
9.12 The Members considered that removal was open to the Panel, given the seriousness of Colleague A's conduct, the Registrant's lack of candour and limited insight. However, the Members concluded that there was probably enough in the evidence for the Panel to have concluded that this conduct was out of character, that some insight had been shown and that the Registrant is otherwise a good and competent nurse. Therefore, the Members concluded that the decision to impose a 9-month suspension with a review was not one which no reasonable Panel could have made. In all the circumstances, therefore, it was not insufficient for public protection.

10. Referral to court

10.1 Having concluded that the panel's Determination was not insufficient for public protection, the Members were not required to consider whether they should exercise the Authority's power under Section 29 to refer the case to the relevant court.

11. Learning points

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



07/05/21

Alan Clamp (Chair) **Date**

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 Nursing & Midwifery Council
The Registrant	[redacted]
The Regulator	Nursing & Midwifery Council
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 [redacted]
The Court	The Court of Session
The ISG	Regulator's Indicative Sanctions Guidance