Virtual Section 29 Case Meeting

13 October 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
Simon Wiklund, Head of Legal, Professional Standards Authority
Graham Mockler, Assistant Director of Scrutiny & Quality (Performance), Professional Standards Authority

In attendance
Peter Mant, Counsel, 39 Essex Chambers, Legal Advisor

Observers
Rebecca Senior, Senior Legal Reviewer, 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 High Court of Justice of England and Wales and the statutory time limit for an appeal would expire on 18 October 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]
- Counsel's Note dated 11 October 2021
- Case Examiners' referral Decision and Bundle
- NMC's Bundle
- The NMC's Sanctions Guidance, specifically:
    - Guidance on ''factors to consider before deciding on sanctions", "suspension orders" and "striking off"
    - Guidance on "serious concerns which are more difficult to put right"
- 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.

8. Background

8.1 This was a hearing of the Fitness to Practise Committee of the NMC heard on 9-12 August 2021. The Registrant, a [redacted] attended the hearing and was represented.

8.2 This case involves two allegations of misconduct and a conviction [redacted]. The Registrant was [redacted], to which he pleaded guilty, received a fine and was disqualified from driving for 20 months. One misconduct allegation is linked to the conviction i.e., a failure to inform the NMC.

8.3 The other misconduct allegation arises from the Registrant's employment as a [redacted]. The Registrant had been working on the unit since 3 December 2018. The Authority's concerns in this case stem from this event, not the conviction and associated misconduct.

8.4 On 6 February 2019 the Registrant was responsible for providing pressure care to Patient A. Patient A was elderly, non-mobile, doubly incontinent and suffered from dementia and short-term memory issues.

8.5 The allegations considered by the Panel were that when Patient A was in a hoist, mid-air, being moved from a chair to the bed, the Registrant slapped her bottom approximately 20 times and said ''this is how we give pressure relief. Naughty girl, naughty girl.'' The Registrant was suspended by the Trust and reported to the NMC.

8.6 In relation to the above, the regulatory concern put before the NMC Case Examiners was 'physical abuse of a patient and a failure to treat them with dignity'.

8.7 The Panel found impairment on the personal and public components and that the Registrant had breached one of the fundamental tenets of the profession in placing Patient A at risk of physical and emotional harm. It imposed a six-month suspension order with 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:

Potential health concerns

9.3 The Members noted that the information before the NMC Case Examiners indicated that the Registrant may have a problem with [redacted]. The Members considered that this, coupled with the Registrant's conviction [redacted], should have prompted the NMC to investigate whether there was a potential [redacted] that impaired the

Registrant's fitness to practise. The Members considered the response the NMC provided on this point was inadequate. The suggestion that there was no evidence the Registrant was not managing [redacted] did not address matters such as his hospitalisation for [redacted] or the lack of evidence stemming from the NMC's own failure to investigate [redacted] that are difficult for sufferers to manage.

Sexual motivation

The Members noted the NMC had referenced in its letter to the Authority bringing a charge of sexual motivation against the Registrant. The Members discussed this and agreed that the evidence established behaviour intended to abuse, humiliate and degrade. However, applying relevant principles from case law on sexual motivation, they concluded that the nature of the behaviour and the circumstances in which it occurred were not such that sexual motivation should have been charged.

Under-prosecution

9.4 The Members first considered whether the NMC had under-prosecuted the case in failing to charge that the Registrant's conduct was deliberately abusive. The Members noted that the regulatory concern put before the NMC Case Examiners had been 'physical abuse of a patient and a failure to treat them with dignity'. However, the Members noted that the allegations before the Panel did not include any descriptor for the inappropriate nature of the conduct, such as, abusive, humiliating, or degrading. They further noted that the word 'abuse' does not appear anywhere in the Panel's consideration, nor was it alluded to by the NMC case presenter.

9.5 Further, the Members were not satisfied by the contents of the NMC's letter to the Authority received prior to the case meeting. This mentioned it being contrary to the NMC guidance to include, for example, an allegation of humiliating behaviour, due to its belief that focusing on outcomes is unlikely to be relevant to the regulatory issues. However, the Members considered 'humiliating' and 'degrading' to be descriptions of the Registrant's behaviour and that clinical outcomes were not relevant in this case. They considered the inherent nature of the act committed by the Registrant was humiliating and degrading. However, they acknowledged that this descriptive detail can pose problems when included in charges or allegations. They did however consider that the use of a commonly used descriptor such as 'inappropriate' was required and did not agree with the NMC's view that including such a descriptor would be contrary to its guidance.

9.6 The Members considered that the failure to adequately describe the registrant's behaviour in the charges indicated a failure of the NMC to comprehend the overall seriousness of the Registrant's conduct, leading to the Panel making flawed findings. They therefore concluded that the NMC's failure to prosecute the case on the basis of patient abuse was a serious procedural error.

Findings of fact

9.7 The Members discussed the Panel's acceptance of the evidence of Ms 1 that the Registrant was slapping Patient A using the palm of his hand, yet also accepted the Registrant's evidence that he patted Patient A using a cupped hand.

9.8 The Members considered this acceptance was irrational as it was not possible for both versions to be correct. Further, they considered it perverse and inherently implausible that the Registrant's actions were "a misguided and careless attempt to implement an inappropriate pressure area care technique'' given the patient was at the time wearing a soiled pad, hanging in a hoist, and the Registrant was saying "you naughty girl" and laughing. They took into account the Panel's unsupported view that the Registrant's words might have been a ''misguided attempt at humour'', but considered this was inconsistent with the registrant's evidence that he was carrying out a technique and denied saying the words. The members did not consider there was a proper basis for the Panel to find on the evidence that this was misplaced humour, even taking into account the deference due to it in seeing the Registrant give evidence.

9.9 Further, the Members considered the Registrant's account that he last used the technique in the late 1990's appears incredible, and that there was no independent evidence before it that "cupping" is (or ever has been) a recognised pressure relief technique. None of the NMC witnesses had ever heard of its use and the Registrant adduced no evidence in support of his case.

9.10 The Members therefore considered the Panel's irrational findings were completely out of tune with the evidence before it and that it failed to address the two conflicting accounts adequately in its reasons.

9.11 As a result of the Panel's failure to address these matters, it was not possible to know why the Committee reached the overall decision that it did, and not possible to say whether the impact of this failure meant that the overall decision was "wrong".

Inherent gravity and motive

9.12 The Members considered the inherent gravity of the Registrant's conduct, and the Panel's apparent failure to fully appreciate this throughout the hearing. It was not clear to the Members whether this was a failure of the Panel to provide sufficient reasons demonstrating its concerns or whether it simply failed to appreciate the gravity. They considered that the Registrant's conduct in slapping the bottom of a vulnerable patient whilst saying "you naughty girl" was a conscious act that was inherently humiliating and degrading, and which amounted to abuse, or at least raised a serious concern about the Registrant's attitude to patients. However, the Members noted that at no point was the term 'abuse' referenced by the Panel, nor did the Panel, despite identifying a breach of the requirement in the Code to "treat people as individuals and uphold their dignity", reflect these concerns anywhere in its decision.

9.13 The Members considered there was a requirement for the Panel to assess the particular degree of vulnerability of the Patient and analyse the attitudinal

failings on the part of the Registrant. The Members considered that these were important factors omitted by the Panel.

9.14 The Members considered what the Registrant's motive had been, noting that he had denied saying the words alleged (so there was no direct evidence from him on the issue of motive), and that the Panel had found the Registrant's actions were "not done with ill intent" and had been a ''misguided attempt at humour". However, the Members considered it was not sufficiently clear in the determination whether these issues had been adequately addressed by the Panel, and, even having found misguided humour, in the context of this case it should have gone on to consider the suitability of this Registrant remaining registered as a nurse.

9.15 The Members considered that this failure to place the Registrant's physical actions in their context could have stemmed from the NMC's failure to include a descriptor in the allegations, such as that the Registrant's actions were inappropriate. They considered that a lack of more explicit charges could have led the Panel to trivialise the fact that this behaviour appeared to be abuse of a vulnerable patient.

Sanctions guidance and reasoning on sanction

9.16 The Members considered the Panel's reasoning on sanction with reference to the NMC's sanction guidance. They noted that there were factors present relevant to both suspension and strike off, but that the Panel's decision failed to address relevant parts of the guidance for striking off being the most appropriate sanction. In addition, it failed to address concerns about whether public confidence and professional standards could be maintained if the Registrant was not removed from the register.

9.17 Further, the Members noted that a number of the factors identified in the sanction guidance as indicating that suspension may be appropriate were not present in this case. In particular, there was no indication of insight or remorse.

9.18 In addition, the Members considered the list of aggravating and mitigating factors listed by the Panel and the weighting given to each. They considered the mitigation to be weak, and noted again that lack of insight and attitudinal concerns were missing from the Panel's consideration. They noted, however, the Registrant has practised as a nurse for 40 years without any previous concerns being raised, and that there appeared to be no evidence of previous similar attitudinal concerns. However, the Members considered the Panel had referenced irrelevant factors such as the Registrant's lack of a structured development plan or training to support his return to work following a period out of practice, hostility on the unit, and his difficult personal circumstances, which they considered had little or no bearing on this type of attitudinal misconduct.

9.19 The Members took into account the guidance on sanctions for serious cases, and that this is a case that could be considered under the category 'deliberately causing harm to patients'. They noted that the Panel did not appear to treat this case along these lines, despite the evidence of misuse of power and harm to a vulnerable patient. They concluded that this was therefore a failing of the Panel's approach.

9.20 Further, they concluded the Panel had placed too much weight on personal mitigation, and insufficient weight on the serious and deliberate nature of the Registrant's conduct towards a vulnerable patient. They considered that, given the seriousness, there was a requirement of the Panel to consider fundamental incompatibility and provide adequate reasons for not considering a striking off order to be the proportionate sanction.

Conclusion on insufficiency for public protection

9.21 The Members noted that a six month suspension is a serious sanction. However, they considered in all the circumstances of this case that the Panel's decision to impose a suspension was insufficient for public protection.

9.22 In light of their concerns, the Members concluded that that as a result of errors in the way that the case was prosecuted by the NMC and considered by the Committee, there was a serious procedural irregularity which meant the Members were unable to determine whether the outcome of the case was insufficient.[2]

Referral to court

9.23 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.

9.24 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.

9.25 The Members also noted that the Registrant [redacted] and that an appeal could be distressing and impact further on his [redacted]. The Members also considered whether there was any way to secure public protection without referring this decision to the relevant court.

9.26 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.

30/11/21

Alan Clamp (Chair) **Dated**

[2] *Ruscillo* at [72]

10. Annex A – Definitions

10.1 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 & 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]
The Court	The High Court of Justice of England and Wales
The SG	Regulator's Indicative Sanctions Guidance in force at sanction stage