Section 29 Case Meeting

25 November 2022

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

Primrose Matovu Namusisi

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
David Martin, Concerns & Appointments Officer, Professional Standards Authority
Mark Stobbs, Director of Scrutiny & Quality, Professional Standards Authority

In attendance
David Mitchell, Counsel, 39 Essex Chambers

Observers
Rachael Martin, Scrutiny Team Coordinator, Professional Standards Authority
Rebecca Moore, Scrutiny Officer, 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 5 December 2022.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 30 September 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 30 September 2022
- The Authority's Detailed Case Review
- Transcripts of the hearing dated 26 September 2022 – 30 September 2022
- Counsel's guidance note dated 25 November 2022
- Exhibits
- CE Masters Bundle
- CE Decision letter to Registrant
- The NMC's Sanctions Guidance

7.2 The Members and the Legal Advisor were provided with a copy of a response from the NCM to the Authority's Notification of s.29 Meeting. The Members considered the response having received legal advice and after they reached a conclusion on the sufficiency on the outcome.

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

8. Background

8.1 The Registrant was employed as a bank learning disability nurse at the material time.

8.2 The incident occurred during the night shift on 8 to 9 June 2019. The Registrant was one of two mental health nurses allocated to provide two to one care to Patient A for the entirety of her shift. Patient A suffered from Parkinson's and had additional needs due to hospital developed pneumonia. Patient A was also producing thick secretions and due to his current condition was at risk of aspiration. When Patient A was not in bed, he risked falling due to his comorbidities, and was considered a vulnerable patient for these reasons. Due to the complexities in managing his condition, Patient A was allocated a side room.

8.3 At 3am on the morning of 9 June 2019 the Grandson of Patient A attended the hospital to visit Patient A. Upon reaching his room, he could not gain access as it was locked. He tried knocking for several minutes but there was no response. Due to his concern, he was joined by Witness 2 (the sister in charge at the time) who also had to knock for one to two minutes and call out "hello" to gain access. Eventually, the Registrant opened the door a little, and then closed it again. When the Registrant reopened the door a few minutes later, it appeared to both witnesses that she had just woken up because of her appearance and as the room was in virtual darkness. Patient A's Grandson also saw blankets rolled into pillows and other blankets on the chairs which gave him the impression that the Registrant had been sleeping on a makeshift bed.

8.4 When Witness 2 turned the light on, Patient A's Grandson and Witness 2 found Patient A unresponsive on the bed with his head lowered down below his legs, and his legs bent but elevated at a 45-degree angle and his night-clothes bunched up under his arms. Patient A's head was against the headboard and touching the bedrails which were raised. Patient A had mucus all over the right side of his face and was at a high risk of aspiration.

8.5 When Witness 1 listened for Patient A's breathing, he heard gurgling, and there were no clinical monitoring machines in the room that would have detected his conditions. Witness 2's evidence was that it took around two hours to stabilise Patient A, clean him and make him comfortable.

8.6 The Registrant made partial admissions including that she had locked Patient A's door without any clinical reason. She told the Panel that they had maintained constant observation within eyesight of Patient A, did not fall asleep during any time of the shift, that Patient A was not at risk of aspiration, and that the secretions on his face were because of Patient A suffering a coughing episode a few minutes before Patient A's Grandson and Witness 2 entered the room. In her evidence the Registrant also insisted that Patient A's head was supported by a pillow and that Patient A's head was higher than his legs.

8.7 The Panel found all allegations proved and imposed a 12-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:

Undercharging

9.3 The Members considered whether there was a failure to bring a charge regarding false imprisonment. The Registrant admitted locking Patient A's door without any clinical reason. However, this factor was not investigated or proceeded with on the basis that it could have been an incident of false imprisonment. Whilst Patient A had a Deprivation of Liberty Safeguard (DOLS) it is apparent from the Registrant's admission that the door was not locked on this basis.

9.4 The Members were not satisfied that there was sufficient evidence to suggest that the Registrant had locked the door for clinical reasons and concluded that this was not done in a clinical context. In fact, in her evidence the Registrant appeared to indicate that Patient A was difficult to keep in bed and generally there was a desire to keep him away from other patients which appeared to be the basis for locking the door.

9.5 The Members did not consider that a charge around Deprivation of Liberty would have added to the overall seriousness of the allegations considered. Patient A's door certainly should not have been locked and the matter would have been of greater concern if there was evidence that Patient A tried to exercise his liberty. The locking of his door prevented his Grandson and other clinical staff accessing the room. However, it was clear that the Panel was aware of the seriousness of the allegation even though it was not formally charged.

Harmful deep-seated personality or attitudinal problems

9.6 The Members considered whether it was wrong for the Panel to have determined that some attitudinal issues were present, but that there was no evidence to suggest that these may be deep seated.

9.7 The misconduct in this case appears to have been planned rather than being spur of the moment and represented a very serious and dangerous approach to care. This did suggest an attitudinal problem may be present.

Insight

10. The Members considered whether the Panel gave sufficient consideration and reasons to the SG regarding suspension orders and in particular the Registrants lack of insight and the risk of repetition identified in this case.

10.1 The Members noted that the Registrant's insight was identified by the Panel as an aggravating factor. The Panel's findings were that the Registrant's conduct was deliberate, pre-meditated and selfish and placed Patient A who was highly vulnerable at serious risk of severe harm. Furthermore, despite having admitted

some of the charges, the Registrant maintained her account, leading to the conclusion that her admissions were not genuine. Whilst this is not a finding of dishonesty, it nonetheless raises an issue of integrity which the panel was required to weight in the overall balance.

10.2 Similarly, it was found that the Registrant lacked insight, minimised the seriousness of her misconduct and deflected blame onto others. Significantly, the Panel concluded that there was a *"significant risk of repetition as you have not remediated your misconduct."*

10.3 The Members considered that the fact that the Registrant had subsequently worked for three years without any regulatory concerns being raised had limited weight and should not have been treated as decisive when ruling out a striking off order. The Panel considered the misconduct a "near miss of serious injury or death" case with a "significant risk of repetition" in which the Registrant lacked insight. The Members concluded that this was a serious case of misconduct concerning fundamental care responsibilities in nursing where a registrant had shown no insight. The Members struggled to see how the Panel had fully considered its findings when considering the SG, particularly when a significant risk of repetition had been identified.

The Panel's reasons for imposing a suspension

10.4 The Members considered whether the Panel's reasons for imposing a suspension order were robust given the seriousness of the misconduct.

10.5 The Panel recognised the seriousness of the misconduct and appear to have considered this. They identified that the Registrant had displayed some attitudinal issues and the Members acknowledged that the Panel's comment that there was no evidence to suggest any deep-seated attitudinal problems was a value judgment that the Panel were entitled to make having heard her evidence.

10.6 The Members felt that a compelling argument was required as to why striking off was not required in this case. The conduct was fundamentally wrong. The Panel had made serious findings of misconduct, the Registrant had continued to make denials at the hearing and repetition had been identified as a risk. The Panel placed too much emphasis on the public protection angle rather than public confidence and interest.

Sanction

10.7 The Members considered whether the sanction sufficiently addressed the misconduct found proved and whether it was reasonable in terms of the serious misconduct found proved.

10.8 They noted that the Panel had found that the Registrant's conduct was deliberate and premeditated. Patient A was an extremely ill and vulnerable patient requiring two to one care. The Registrant deliberately took away Patient A's blankets for her own use, placed him in a dangerous position to prevent movement and locked the door so that her actions would go undetected. This could never be considered appropriate behaviour from a nurse. The registrant provided no excuse for her behaviour, denied it and there was nothing to suggest any insight into its seriousness.

10.9 The Members were concerned that the Panel had placed too much emphasis on its (unreasoned) view that the misconduct was remediable and, therefore, not fundamentally incompatible with continued registration. It had not weighed the question of whether there was, in fact, a likelihood of remediation and, in the addition, the sheer seriousness of the conduct. It appeared to have focused on remendability at the expense of the public interest in upholding professional standards.

10.10 The Members concluded that a suspension order was the wrong outcome as the Panel had failed to deal with the inherent seriousness of the misconduct. The Members concluded that the decision to suspend the Registrant was irrational when looking at the case a whole.

Conclusion on insufficiency for public protection

10.11 The failure of the panel to properly weigh the very serious misconduct against the very limited mitigation and the absence of insight resulted in the Members concluding that the Panel's decision to impose a 12-month suspension with a review was insufficient for public protection.

11. Referral to court

11.1 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.

11.2 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.

11.3 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.

13/12/22

Alan Clamp (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 Panel of the NMC
The Registrant	Primrose Matovu Namusisi
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 30 September 2022
The Court	The High Court of Justice of England and Wales
The SG	Regulator's Indicative Sanctions Guidance