Virtual Section 29 Case Meeting

24 March 2022

157-197 Buckingham Palace Road, London SW1W 9SP

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Kisha Punchihewa, Head of Legal, Professional Standards Authority
Simon Wiklund, Head of Legal, Professional Standards Authority

In attendance
Andrew Deakin of 39 Essex Chambers, Legal Advisor

Observers
Rebecca Moore, Senior Scrutiny Officer, Professional Standards Authority
Colette Byrne, Senior Scrutiny Officer, Professional Standards Authority
Briony Alcraft, Scrutiny Team Co-ordinator, 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 One of the Members declared that he was responsible for instructing Counsel before he was chosen as a decision maker. He declared that he has seen the regulator's response to our request for comments, but has not taken these into account at this stage. The Member was satisfied that he was not familiar with this Registrant or the case. The Members concluded that in the circumstances there was no conflict 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 1 April 2022.

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 22 March 2022
- Hearing Bundle
- Case Examiners' Decision
- NMC guidance documents –

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

- Serious concerns which are more difficult to put right
- Serious concerns based on public confidence or professional standards
- Considering sanctions for serious cases

- 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. 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 This is a mixed conviction and misconduct case. The Registrant is a nurse who was employed as a health visitor.

8.2 **Conviction:** On [redacted], the Registrant was convicted of causing serious injury by dangerous driving. By way of background, on [redacted] the Registrant was driving to her first appointment that day in a vehicle leased from her employer. The Registrant was distracted by a phone call when she failed to give way at a junction. She had to swerve to avoid a collision and in doing so she pressed the accelerator rather than the brake. Her car collided with a ten-year-old girl who was on her way to school. The girl suffered life changing injuries to her legs. The evidence available suggests that the victim may not be able to walk again.

8.3 The Registrant was cautioned by police at the scene of the accident – when asked for her account she said that she had been using the satellite navigation on her telephone. She was formally interviewed by the police on [redacted] and asserted that she had not been on the telephone.

8.4 The Registrant pleaded guilty on the first day of the trial (there had been a delay in sharing relevant CCTV evidence which captured the events which may have led to the delay in her guilty plea). She was sentenced to 20 months' imprisonment, disqualified from driving for three years, and ordered to pay a victim surcharge. The sentence came to an end in [redacted].

8.5 **Misconduct:** The Registrant discussed the accident with her employer on [redacted] and, on each of these occasions, denied that she had been on the telephone at the time of the accident. The misconduct element of the case flows from these meetings. The Panel found that the Registrant had lied when asked by her employer whether she had been on her phone at the time of the accident. Dishonesty was proven, and the Panel found her actions fell seriously short of the standards expected of a nurse and amounted to misconduct.

8.6 The Panel did not, however, find impairment in relation to the conviction or the misconduct.

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:

Did the Panel adequately assess the seriousness of the registrant's conviction?

9.3 The Members were concerned that the Panel's reasons contained very little reference to the seriousness of the events that led to the conviction which meant it was not possible to understand whether the Panel had taken all relevant information into account when reaching its decision on impairment.

9.4 The Members discussed whether the Panel had properly considered the material aspects of the Registrant's actions which led to the conviction. This included the objective seriousness of the events, such as the fact that she was distracted by a phone call, that her initial response was to blame the other driver, and her denials and differing accounts of the events.

9.5 The Members were also concerned that the Panel had failed to engage with the fact that the Registrant was using a car leased from her employer and on her way to her first appointment of the day – thus clearly creating a link between her actions and her role as a nurse.

9.6 The Members noted the absence of any reference to the Judge's sentencing remarks (which gave a clear description of the seriousness of the incident and the impact on the junior victim). This information was available to the Panel but it was not clear that it had given adequate consideration to it. Further, the Members considered the Panel had failed to pay due regard to the fact that a custodial sentence had been imposed and that the Judge had made it clear there was an expectation the Registrant would lose her job, (though whether this was in relation to the result of a regulatory hearing or employer action was not clear).

9.7 In the absence of a properly reasoned decision, the Members considered that the Panel failed to appreciate the seriousness of the Registrant's offending and its potential impact in bringing the profession into disrepute and undermining trust and confidence in nurses. They concluded that this was a procedural error.

Did the Panel err in principle in its finding on impairment?

9.8 Next, the Members discussed the Panel's approach to impairment, in particular its consideration of the public interest in a criminal conviction case where a custodial sentence was imposed.

9.9 The Members considered the Panel appeared to have misunderstood the fundamental differences between the aims of the criminal justice system and the role of regulatory proceedings. The Members noted the Panel's comments that:

'an informed member of the public would consider that the public interest had been marked by the custodial sentence that you had served. The panel was satisfied from the remorse and insight you displayed in your compelling oral

evidence and written reflections that such an event would never be repeated, in particular the steps you have taken in order to ensure that you will be a safe driver in the future.'

9.10 The Members noted that criminal proceedings have a different purpose to regulatory proceedings. The public interest in fitness to practise proceedings could not be satisfied by the fact that the Registrant had served time in prison: the prison sentence was imposed to satisfy the aims of the criminal justice system, i.e. punishment.

9.11 The Members considered that the Panel may have erred in taking into account matters that were relevant to the sanction decision at the impairment stage. The public interest in a nurse returning to practice was not a relevant consideration at this stage. The Members considered this this may have been an error of approach.

9.12 The Members considered the Panel was wrong to reach the view that the Registrant's dishonesty was "not directly linked" with and did not "arise in the context of her" practice as a nurse. It appears that the Panel failed to appreciate that the incident took place while the Registrant was travelling to an appointment in the course of her work as a health visitor in a vehicle provided by her employer. The Members considered this to be an additional error in divorcing this criminal offending from her professional practice, and in the Panel concluding this was not relevant to her fitness to practise.

9.13 Further, the Members noted the large number of supportive testimonials submitted by the registrant. However, they noted the dates of these and that they appeared to have been written for the criminal sentencing or investigation stage of the NMC proceedings. They considered that it was not clear from these whether the writers were aware of the findings that the Panel had made at the earlier stages. The Members wondered how much weight the Panel had given to this testimonial evidence, which was not fully informed. They concluded that the Panel had erred in relying on these testimonials.

9.14 In addition, the Members discussed the Panel's approach to personal mitigation and considered that the Panel had given improper weight to the Registrant's remorse, contrary to the approach established by case law.

9.15 The Members discussed the case law set out in *Uppal*[2], indicating that while a finding of dishonesty may not necessarily lead to a finding of impairment it would be an exceptional case for it not to do so. The Members did not consider there to be anything exceptional about this case.

9.16 They noted further that the Panel did not reference any case law on dealing with cases involving dishonesty.

9.17 Nor did the Panel indicate that the decision was a finely balanced one.

9.18 The Members, therefore concluded that the Panel had repeatedly fallen into error and had failed to give sufficient reasons for its findings that the Registrant's fitness to practise is not impaired.

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[2] *Professional Standards Authority for Health and Social Care v General Medical Council & Uppal* [2015] EWHC 1304 (Admin)

Conclusion on insufficiency for public protection

9.19 In light of their concerns, the Members concluded that, given the seriousness of the offending and the misconduct and the Panel's errors in approach, the failure to find impairment was a serious procedural irregularity which meant the Members were unable to determine whether the outcome of the case was insufficient.[3]

9.20 Having reached its view on sufficiency the Members considered the NMC response to notification of the case meeting. The Members considered there was a considerable overlap with the concerns set out by the NMC in its letter to the Authority, and that this reinforced the Members' decision on insufficiency.

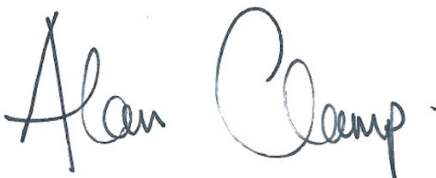
10. Referral to court

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 were conscious of the trauma and difficulties this registrant has experienced through the criminal and fitness to practise proceedings. However, they were mindful of the need to uphold public confidence in the profession and the requirement for the issues highlighted in this case to be re-examined. The Members concluded that there were no alternative means available to secure public protection.

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.



11/05/22

Alan Clamp (Chair) **Dated**

[3] *Ruscillo* at [72]

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 Panel of the NMC
The Registrant	
The Regulator	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
The Court	The High Court of Justice of England and Wales