Section 29 Case Meeting

26 October 2021

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

Sally Louise King

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Mark Stobbs, Director Scrutiny & Quality, Professional Standards Authority
Rebecca Senior, Senior Legal Reviewer, Professional Standards Authority

In attendance
Michael Standing, Counsel, 39 Essex Street Chambers

Observers
Michael Hannah, Scrutiny Officer, Professional Standards Authority
Rachael Martin, Team Coordinator, Professional Standards Authority

This meeting was held virtually in light of the current health pandemic.

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 November 2021.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 31 August 2021.

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 31 August 2021
- The Authority's Detailed Case Review
- Transcripts of the hearing dated 31 August 2021
- Counsel's Note dated 25 October 2021
- CE Decision letter
- CE Masters
- Substantive Meeting Exhibits
- Meeting decision letter
- 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. 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 At the material time the registrant worked as the Nurse Manager at a Medical Practice. In 2018 a CQC inspection revealed that several Patient Group Directions (PGD) had been signed inappropriately. The CQC concluded that the Practice required improvement and a follow up inspection was due on 7 February 2019.

8.2 The registrant kept the signed PGDs in a folder in her room. The registrant claimed that, about one week before the inspection, she was reviewing the PGD documentation and realised it was not complete as some were not signed off by the authorising manager. She took the folder home. She could not find completed documents. During the local investigation she said that she forged Dr RG's signature on those documents (Dr RG being the authorising manager) and did not forge any other signatures.

8.3 In fact, the registrant had created new PGDs and in so doing forged the signatures of 2 nursing colleagues and Dr RG. She stated that she only replicated the forms that she knew had been signed– she did not create one for typhoid as she was not sure that there had ever been an original document.

8.4 On 7 February 2019, the CQC inspectors identified that the PGD for the typhoid vaccine was missing. The inspectors requested information on how many patients had received the vaccine since the previous PGD had expired. The GP partners discovered the registrant's deception when gathering this data. Dr RG was looking in the PGD folder and noted what she considered to be forgeries of her signature.

8.5 On 8 February 2019 Dr RG met with the registrant. The registrant admitted that she had forged Dr RG's signature on the forms identified in the meeting. She told Dr RG that there was nothing else she needed to know. The practice suspended the registrant during the investigation.

8.6 On 11 February 2019 Dr RG met with the registrant a second time. During this meeting, Dr RG asked the registrant if the signatures of the nurses, DD and KM, were genuine. The registrant confirmed that they were.

8.7 After this meeting the registrant contacted DD and KM. She told them she had forged their signatures and asked them to lie and claim the forged signatures were theirs. It was during these calls that the registrant said that the Practice could be closed if they did not support her story (she claims that this was because of what Dr RG had said to her). The NMC case was this was an attempt to place undue pressure on these colleagues to maintain the deception. This conduct did not come to light until July 2019.

8.8 Between 12 and 14 February 2019 Dr RG interviewed DD and KM. Four forged signatures were identified. The Practice gave the registrant a 12-month warning.

8.9 In July 2019, as part of an unrelated grievance, DD said that the registrant had asked DD to lie to cover up the registrant's dishonesty. KM confirmed the same had happened to her.

8.10 The Practice referred the registrant to the NMC.

8.11 The registrant admitted all the charges brought by the NMC. The case was considered at a meeting. While the registrant provided written submissions for the case examiners, she does not appear to have provided any additional documentation for the final hearing.

8.12 The Assistant Registrar rejected the registrant's request for voluntary erasure.

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 appropriately consider the seriousness of the misconduct?

9.3 The Members considered whether the panel had grappled with the true seriousness of the misconduct and whether this was identifiable in the determination.

9.4 The Members noted that there is no express reference to the SG and in particular the SG which includes "considering sanctions for serious cases" in the decision. The Members also considered the panel's decision confusing. It was not clear what the panel found in terms of risk and public protection. The Members further considered that the decision was full of standard phrases regularly used in decisions which bore little relevance to the issues the case raised.

9.5 The Members were concerned that the panel appeared to have considered the allegations as a single instance of dishonesty when this was not the case. The registrant did not disclose her dishonesty despite being given several opportunities to do so. In the Members opinion this made her conduct more serious and gave rise to concerns regarding attitude and candour.

9.6 Furthermore, the registrant attempted to persuade junior colleagues, one of whom she line managed, to lie. While arising from the same instance of misconduct, in the Members opinion these actions made it difficult to view this as a single instance of dishonesty. The fact that the panel had characterised the incident as a single incident suggested that they had not understood the seriousness of the matter.

Did the panel correctly approach the issues of insight and remediation?

9.7 The Members considered whether the Panel should have addressed all the relevant factors set out within the SG and their specific findings on insight and risk of repetition.

9.8 At the impairment stage, the panel noted that the registrant had not demonstrated insight into her actions due to her failure to provide a reflective piece that addressed the impact of her actions. The panel considered the misconduct capable of remediation but that there was no evidence of remediation. The panel also considered that there was a risk of repetition.

9.9 The Members noted that one of the factors noted within the SG as being indicative of a suspension being an appropriate sanction is, *"the Committee is satisfied that the nurse, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour."*[2] The Members were concerned that, having previously found that there was a risk of repetition and that the registrant had not shown insight, the panel did not explain why these findings were not taken into account at the sanction stage or why, despite them, a suspension was appropriate in this case.

Was all the relevant information placed before the panel?

9.10 Having had sight of the Case Examiner's bundle the Members considered whether a document by the Director of Quality and Nursing from the Clinical Commissioning Group which was produced following a meeting with the registrant in July 2019 should have been placed before the panel.

9.11 The document highlighted concerns regarding potential lack of integrity and possibly dishonesty. The document indicated that the registrant had allowed another person to sign her reflective accounts paperwork, to confirm that discussions had taken place when they had not. No allegations were brought against the registrant in relation to this incident.

9.12 The Members considered that this evidence ought to have been seen by the panel as it was potentially indicative of repeated dishonesty. The Members considered it relevant to impairment and sanction as there was already an inquiry into the registrant's integrity when this incident occurred. The Members noted the similarity in that both incidents concerned forged documents and how the registrant chose to deal with them. For example, it was noted in the document that the Registrant 'completely panicked', which is the same response given in relation to the other incidents. The Members were concerned by the decision not to investigate this further incident further by the NMC as it was clearly material to the assessment of the misconduct and likelihood of further repetition.

Did the panel provide adequate reasons for their decision on sanction?

9.13 The Members considered whether the panel had given sufficient reasons for their decision to suspend the registrant rather than erase.

[2] Sanctions Guidance page 17

9.14 The Members felt the decision was poorly drafted and contained a number of 'stock' phrases which bore little relevance to the issues the case raised. While the panel were entitled to state that the registrant had shown some insight based on her admissions, they also made several comments regarding the risk of repetition indicating limited insight. The Members concluded that the panel needed to be clearer in their comments on insight as to the level of insight shown by the registrant. The Members considered that the sanction decision did not adequately explain why the panel found the misconduct to be remediable given the cover ups and lack of insight.

9.15 The Members also found the panel's decision on impairment difficult to follow. The allegations were noted as not raising public protection concerns but the Members were concerned that the panel failed to fully address the registrant's attitudinal issues and her repeated dishonesty. Furthermore, the panel said it considered the misconduct remediable but did not indicate how this could be achieved, given the registrant's limited insight and her intention never to work as a nurse again.

9.16 The Members concluded that the panel's reasons were inadequate. This was very serious conduct involving repeated dishonesty. It is not evident from the panel's reasoning that it fully grappled with this. Furthermore, the Members considered that there was no evidence to support one of the mitigating factors (the context surrounding the incident). The Members questioned whether the panel had given too much weight to irrelevant factors when choosing to suspend. Overall, the Members considered that the balance struck in favour of the mitigating factors undermined the sanction decision.

Was the decision to suspend, rather than erase, wrong?

9.17 The Members considered that, had the panel been provided with the document noting a further potential instance of dishonesty by the registrant, it would have had to consider more closely whether erasure was warranted.

9.18 The Members considered that the reasoning was so poor in this case it was difficult to establish why the panel had chosen to suspend rather than erase. The Members considered that with appropriate reasoning, it might have been possible for a panel to conclude that a suspension was appropriate. However, the reasons given by the panel were not adequate to explain its thinking in this case.

9.19 The Members concluded that given the number of instances of dishonesty coupled with a lack of insight suggested that the Registrant may have a harmful deep seated attitudinal problem which is more difficult to remediate. The Members considered that there were a number of aggravating factors in this case which, suggested that erasure may have been appropriate. The Members discussed that these factors were consistent with those in the NMC sanctions guidance which indicated that erasure may have been appropriate.

Conclusion on insufficiency for public protection

9.20 The Members concluded that the panel's decision to suspend the registrant was insufficient for public protection. The Members were concerned that there had been a failure to fully investigate a further potential instance of dishonesty which

may mean that the case was under prosecuted. The Members were concerned with the response from the NMC in which they said it would have been disproportionate to investigate these matters. The NMC noted that the more serious allegations of dishonesty were pursued and the additional matter was unrelated. The NMC further noted that it would have been disproportionate to investigate the additional matter. The Members strongly disagreed and considered that this approach was not consistent with the overarching objective.

9.21 The Members felt that the panel had failed to fully grapple with the seriousness of the misconduct. The registrant's abuse of her position to put pressure on colleagues to conceal her dishonesty her failure to initially admit her conduct exacerbated the seriousness of the misconduct. Furthermore, the panel failed to give adequate reasons at the sanctions stage as to why a suspension was appropriate over erasure.

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 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.

16/11/21

Alan Clamp (Chair) **Dated**

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	Sally Louise King
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 31 August 2021
The Court	The High Court of Justice of England and Wales
The SG	Regulator's Indicative Sanctions Guidance