Section 29 Case Meeting

20 June 2022

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

[redacted]

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Dan Scott, Accreditation Officer, Professional Standards Authority
Mark Stobbs, Director of Scrutiny & Quality, Professional Standards Authority

In attendance
Peter Mant, Counsel, 39 Street Essex Chambers,

Observers
Remi Gberbo, Lawyer, Professional Standards Authority
Rachael Martin, Team Coordinator, Professional Standards Authority
Rebecca Senior-Carroll, Senior Legal Reviewer, Professional Standards Authority
Simon Wiklund, Head of Legal, Professional Standards Authority
Michael Wole-Ajibode, Comms & Marketing Assistant, 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 24 June 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 20 June 2022
- Exhibits
- CE Masters
- CE Decision Letter to Registrant
- Decision Letter to Registrant
- The NMC's Indicative Sanctions Guidance

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

- 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 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 The allegations arose following a referral from the Registrant's former employer, [redacted] ('the Trust'). The Registrant, a registered adult nurse, was employed as a Staff Nurse at the Trust from [redacted]

8.2 [redacted], the Registrant was providing cover for a nurse in the High Dependency Unit ('HDU') and was responsible for the care of Patient 1, a vulnerable patient with limited capacity who had been under anaesthesia/ventilation and was in a confused state and had been shouting, hitting and scratching staff. At the material time the Registrant was on shift with a junior staff Nurse and Healthcare Assistant.

8.3 The Registrant was found to have said *'I'm* [redacted] *you know and if you hurt me, I will smack you between the eyes'* and *"Do that again and I will smash you in the face*" or words to that effect. It was further found that the Registrant had applied an inappropriate restraint in that she had put her hand beneath the patient's chin, forced her head back and used excessive force.

8.4 The Registrant was suspended by the Trust on [redacted] and following a disciplinary investigation, was dismissed and referred to the NMC.

8.5 During the Registrant's disciplinary interview held on 24 January 2020 she denied having said "*I'm* [redacted] *you know and if you hurt me I will smack you between the eyes".* She stated that she had no recollection of what she said and had been jokingly retelling a story to Nurse 1 about a previous patient they had looked after on ITU who reminded her of Patient 1 but was not directing the conversation at the patient.

8.6 The Registrant's account was that the patient had begun pinching and grabbing at her as she was attending to the TPN alarm and then had grabbed her scissors out of her pocket and that she was concerned that she may harm herself. She therefore scooped her arm under her right hand and put her right thumb on her face to distract her and gently moved her head. She agreed that she had said *"do no touch me or you will hurt yourself"* more aggressively than she should have although had been following what she had been taught in conflict resolution training. She expressed surprise that no one present had noticed the scissors as they were bright pink.

8.7 The Registrant stated that she considered that her actions had been appropriate and proportionate as she had been trying to keep the patient safe and that she did not know what else she was supposed to do to ensure she did not hurt herself or others.

8.8 At the substantive hearing of the NMC's Fitness to Practise Committee the Registrant did not admit any of the allegations.

8.9 The Registrant did not participate in the proceedings, nor was she represented. The Registrant's reflective statements were before the Panel for consideration.

8.10 In the Registrant's reflective statement, she acknowledged that after [redacted] away from the stress and pressure of ITU she probably should not have been back at work and that she had not been in a good mental state since her [redacted], [redacted]

8.11 The Registrant's reflections were that she should have insisted on a handover of all patients in the unit, she should not have discussed a previous patient in the vicinity of another patient, she should have called security or a senior nurse when the patient had become combative and that she should have ensured that her scissors were not accessible to the patient. The Registrant also referred to the NMC Code and accepted that she had failed to treat Patient 1 with kindness respect and compassion and that she had acted compulsively and should have been more objective.

8.12 The Panel rejected the Registrant's account and found all allegations proved. It further found that the Registrant's actions amounted to misconduct. The Panel found impairment on both public protection and public interest grounds and imposed a suspension order for 12 months with a review hearing to be held.

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:

Fundamental incompatibility

9.3 The Members considered whether the Panel was wrong to find that the Registrant's conduct was not fundamentally incompatible with continued registration.

9.4 The Members noted that the Panel had not provided reasons for its conclusion. It was also arguable that it had not fully articulated or appreciated the sheer seriousness of the Registrant's conduct to a vulnerable patient. However, it was equally not unreasonable for the Panel to have concluded that a single incident of misconduct as in this case was remediable, particularly, when there were also other things going on in the Registrant's personal life which may have impacted on her judgment at the material time.

9.5 The Members concluded that, despite the Panel's lack of reasons for saying that the Registrant's conduct was not fundamentally incompatible with continued registration, but it was not wrong for them to make this finding.

No evidence of harmful deep-seated personality or attitudinal problems

9.6 The Members considered whether it was wrong for the Panel to have found that there was no evidence of harmful deep-seated personality or attitudinal problems and whether the Panel provided sufficient reasons for their findings.

9.7 The Members were mindful of the Registrant's comments to Witness 1 *"I don't care if someone hurts me, I'll hurt them back"*- which were not referred to in the determination as well as the investigatory interview and later reflections. This was not referred to in the decision and the Members considered whether this was absent from the Panel's considerations and if this was an indication of harmful deep-seated personality or attitudinal problems.

9.8 The Members considered that the Panel's decision was lacking in reasoning on this matter. However, they also felt it was open to the Panel to have made this finding on the basis that the misconduct found proved was isolated, so it would be difficult to determine that the Registrant's behaviour was deep-seated.

The Approach to Insight

9.9 The Members considered whether the Panel's finding that the Registrant had "limited and developing" insight was wrong, given her denials and reflections. The Panel recognised that the Registrant's reflections were based on a version of events that it found not to be credible. However, in the decision, the Panel did not directly address what (if anything) the rejected defences said about the Registrant's overall insight.

9.10 The Members were mindful of the authorities on the subject and that insight did not necessarily depend on the Registrant fully admitting the conduct.

9.11 The Members considered insight is about recognising triggers and working out strategies where you went wrong and how these can be addressed in the future. This was not a case where there had been a complete fabrication of facts or an attempt to blame others. The Registrant had shown some reflection within the context of acknowledging that the Patient was being difficult, and that she overreacted in the circumstances. The Members considered whether the Registrant could be expected to have fully reflected on her conduct if she was still maintaining her own different account of the incident.

9.12 The Members concluded that the Panel's finding that the Registrant had limited and developing insight was open to it in the light of some statements made by the Registrant, indicating that she had recognised that there had been errors. The Panel had also weighed these against statements which suggested a lack of insight and it was hard to show that the Panel's assessment was wrong.

Affording an opportunity to remediate and develop insight

9.13 The Members considered whether the Panel was wrong to decide that removal would be disproportionate because suspension would afford the Registrant an opportunity to remediate and develop insight.

9.14 The incident took place in [redacted] and notwithstanding that the Registrant stated that she would like to take a refresher course, no evidence of remediation was provided. The Members considered whether the Panel's approach was flawed

approach based upon what was described in *Judge*[2] as "*unsupported wishful thinking".*

9.15 The Members considered that this was a less extreme case than the *Judge* case and that, given that some insight had been found, it might be possible for the Registrant, over the year, to reflect on the Panel's findings, gain insight and provide evidence of remediation. The Members therefore considered that it open to the Panel to give the Registrant an opportunity to demonstrate this.

The Sanctions Guidance

9.16 The SG was incorrectly paraphrased by the Panel. The Members considered whether this incorrect paraphrasing reflected a general error of approach and whether having regard to the proper wording the sanction was wrong.

9.17 The Panel considered the factors identified in the SG as being indicative of a suspension order being the most appropriate sanction and concluded that all of the criteria were met in this case. The Panel, in paraphrasing the guidance stating*, 'the Committee is satisfied that the nurse or midwife has some insight*', misdirected itself in failing to consider the requirement of there not being significant risk of repeating the behaviour and thereby failed apply the guidance properly.

9.18 The Members were mindful that the SG was a guide and not prescriptive. While this was a clear error by the Panel, the Members did not consider that it was sufficient of itself to render the decision wrong. There were other factors that made it open to the Panel to impose a suspension.

Conclusion on insufficiency for public protection

9.19 The Members concluded that this was a serious case of misconduct involving threating behaviour to a vulnerable patient who at the time was clearly confused. There were serious concerns about the Registrant's insight and the lack of detail in the Panel's reasons. It would have been open to the Panel to remove the Registrant. However, the Members considered that there was enough in the Registrant's reflections to allow the Panel to afford her the opportunity to remediate and develop insight. The Members were also mindful that the suspension will be reviewed.

9.20 Despite their concerns set out above the Members concluded that the decision was not one which no reasonable Panel could have made and, 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.

[2] PSA v NMC (1) Judge (2) [2017] EWHC 817 (Admin)

11. Learning points

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

30/06/22

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	[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 High Court of Justice of England and Wales
The SG	Regulator's Indicative Sanctions Guidance