Neutral Citation Number: [2023] EWHC 3331 (Admin)

Case No: CO/1123/2023 and
AC-2023-LON-000288

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21/12/2023

Before :

THE HONOURABLE MR JUSTICE MORRIS

- -

Between :

PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE	**Appellant**
- and -	
(1) NURSING AND MIDWIFERY COUNCIL **(2) KADIATU JALLOH**	**Respondents**

- -
- -

Peter Mant (instructed by **Browne Jacobson LLP**) for the **Appellant**
Helen Guest (instructed by **Nursing and Midwifery Council**) for the **First Respondent**
The **Second Respondent** appeared in person

Hearing dates: 8 November 2023

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Approved Judgment

.....

Mr Justice Morris :

Introduction

1. This is an appeal from a decision ("the Decision") of the Fitness to Practise Committee ("the Committee") of the Nursing and Midwifery Council ("the NMC") dated 17 January 2023. By the Decision, the Committee determined that Kadiatu Jalloh ("the Registrant") should be suspended from the register for impairment of her fitness to practise, arising from misconduct. The Committee found that the Registrant had deliberately assaulted a vulnerable patient ("Patient A") by thrusting a chair at his head and kicking him in the head and further had dishonestly failed to disclose information to a future employer that would have led them to knowing about the assault.

2. The appeal is brought by the Professional Standards Authority for Health and Social Care ("the PSA") under section 29 National Health Service Reform and Health Care Professions Act 2002 (as amended) ("the 2002 Act"). The PSA contends that the Decision was not sufficient for the protection of the public. It asks the Court to quash the Decision and to substitute a striking-off order. This is essentially an appeal against sanction on the grounds that it was too lenient. The NMC has conceded the appeal. The Registrant appears in person and resists the appeal.

3. In this judgment I set out the factual background, address the relevant legal principles, the proceedings before the Committee, the Decision and the grounds of appeal, before turning to my analysis.

The factual background

4. The Registrant is a mental health nurse. The assault occurred on the evening of 11 March 2020 when she was working on the Tyler Ward at Cygnet Blackheath Hospital ("the Hospital"). One of the patients - Patient A - was behaving aggressively towards staff. Patient A slapped and punched the Registrant at around 22:48.

5. CCTV footage covering the period between 22:56:32 and 22:57:18 shows Patient A standing in an empty room holding a chair. 11 staff enter the room, one of whom was holding a second chair. Patient A threw down his chair and was restrained and taken to the floor by six staff. Whilst Patient A is on the floor and fully restrained by others, the Registrant can be seen taking the chair from the colleague who appears to be attempting to remove it from the room. The Registrant then thrusts the chair with two distinct jabbing movements in the direction of Patient A's face or body. It is not however possible on the CCTV to see whether and, if so, where the chair hits Patient A. After thrusting the chair at Patient A, the Registrant can be seen moving her right foot towards Patient A in a kicking or stamping motion. Again it cannot be seen whether or not the Registrant's foot makes contact with Patient A. The Registrant is then seen to rest against the wall and walk around Patient A's body before returning to a position near his head. The Registrant can then be seen swinging her right foot towards Patient A for a second time. At that point the CCTV finishes.

6. On 16 March 2020 Patient A raised allegations about the Registrant's conduct and on 17 March 2020 he spoke to the ward manager. On 27 March 2020 Patient A submitted a written complaint in which he stated that the Registrant had kicked him in the face

three times. The Registrant was suspended from her duties at the Hospital shortly after the complaint was raised.

The internal investigation by, and dismissal from, the Hospital

7. On 6 April 2020 there was an investigatory meeting at the Hospital. On 12 May 2020 the Registrant attended a disciplinary hearing at the Hospital. In the course of the investigatory meeting the Registrant confirmed that she was the nurse in charge. She explained as follows. She was pulling the chair away. As regards the first apparent kick on the CCTV, she was trying to drag her leg away, Patient A was grabbing her leg and her leg was stuck. When asked about the second apparent kick on the CCTV, she said that she did not kick and she could not see why it appeared that way. The Registrant asked why the matter was being looked into and why the investigation was not looking at other matters. She said it was not fair that the whole of the CCTV was not shown. She was surprised she was being accused and she questioned why she had been "picked on". In short, at the investigatory meeting the Registrant maintained a flat denial of what appeared to be happening on the CCTV footage, contrary to the Committee's ultimate findings.

8. On 14 May 2020 the Registrant was summarily dismissed from her employment at the Hospital. The Hospital referred concerns to the NMC.

The application to Homerton hospital

9. Whilst the Hospital investigation was ongoing, the Registrant applied for new employment at the Homerton University Hospital NHS Foundation Trust ("the Trust"). On 30 April 2020 the Registrant completed the application form ("the Application Form"). Under the heading "current/most recent employer (reference always required)", she gave details of previous employment with the Priory Group which ended in 2017 and details of employment with "Cambian Faivour" between July 2017 and March 2018. She did not disclose any information about her employment at the Hospital.

10. On 19 May 2020, a recruitment officer from the Trust wrote to the Registrant stating that the referees provided did not appear to cover the last three years. After a short exchange the Registrant responded stating that Cygnet was her most recent employer and provided an email address.

11. The Registrant subsequently completed the Trust's declaration form dated 21 May 2020 ("the Declaration Form") in which she answered "no" to the following questions:

> "6. Have you ever been dismissed by reason of misconduct from any employment, volunteering, office or other position previously held by you?
>
> 7. Are you currently subject to a fitness to practise investigation and/or proceedings of any nature by a regulatory or licensing body in the UK or in any other country?"

12. Before the Committee the Registrant denied that she had deliberately sought to mislead the Trust. In respect of the Application Form she claimed that this was a standard pre-saved document which she had not changed. She also stated that she did not put down details of her employment at the Hospital because Cambian Faviour is part of Cygnet. As regards the Declaration Form she said that she completed this before receiving the letter of dismissal and had submitted it later without checking. She said she accepted responsibility for the "dishonesty". However she maintained that she had not intended to mislead.

The Interim Order: 11 June 2020

13. On 11 June 2020 an NMC Interim Orders Panel imposed interim conditions upon the Registrant ("the Interim Order") which included the following:

> "1. You must confine your nursing practice to working for Trust Care Solutions Ltd and Pertemps Medical Professionals.
>
> …
>
> 3. You must ensure that you are supervised by a registered nurse any time you are working. Your supervision must consist of:
>
> • Working at all times on the same shift as, but not always directly observed by, a registered nurse.
>
> …
>
> 6. You must immediately give a copy of these conditions to:
>
> a) Any organisation or person you work for.
>
> b) Any agency you are registered with for work.
>
> c) Any employers you apply to for work (at the time of application).
>
> d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study."

Working at Homerton Hospital on 4/5 July 2020

14. At the time the Registrant was registered with various agencies in addition to those listed in the Interim Order. One such agency was Day Webster Group. The Registrant was booked through Day Webster Group to work a night shift for the Trust on 4/5 July 2020. She did not inform the Trust of the interim conditions at any time before she started the shift. At some point in the course of the shift, the clinical site manager discovered that she was subject to interim conditions which meant that she was only able to work for agencies other than the one that she had booked through and that she had to be subject to supervision. The manager spoke to her. She responded that she had informed the agency of the conditions. According to the manager, the Registrant

seemed quite angry and would not leave immediately. The manager ended up saying that she would be forced to call security if the Registrant did not leave. The Registrant was dismissive of the suggestion that it was her responsibility to make sure everyone was aware of the Interim Order restrictions and that she worked within them.

15. Before the Committee the Registrant admitted breach of condition 1 in the Interim Order. She denied breach of condition 3 on the basis that she had been supervised and denied breach of condition 6 on the basis that, first, she sent an email about the conditions to Day Webster (although she got the address wrong) and secondly she did not consider that she was required separately to inform the Trust.

The legislative framework and relevant legal principles

16. The statutory framework for the NMC and the Committee is to be found in the Nursing and Midwifery Order 2001 ("the Order") and the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (SI 2004/1761) ("the Rules"). Other relevant material is to be found in the NMC's Sanctions Guidance and its Fitness to Practise Guidance and in certain case law.

The NMC and the Committee

17. Article 3(4) of the Order provides that "the over-arching objective of the Council in exercising its functions is the protection of the public". Article 3(4A) expands on this, providing that: the pursuit by the Council of its over-arching objective involves the pursuit of the following objectives - (a) to protect, promote and maintain the health, safety and well-being of the public; (b) to promote and maintain public confidence in the professions regulated under this Order; and (c) to promote and maintain proper professional standards and conduct for members of those professions.

Fitness to practise proceedings

18. Article 22(1)(a) of the Order refers to an allegation that a registrant's fitness to practise is impaired by reason of misconduct. Such an allegation is referred to the Committee: Article 22(5). Paragraph 24 of the Rules sets out the procedure for determination of fitness to practise by the Committee. It is divided into three stages: the factual stage, the impairment stage and the sanction stage.

19. Article 29 of the Order provides for sanctions where there is a finding of impairment, including an order directing the registrar to strike the person off the register (a "striking-off order") and an order suspending registration for a period of up to one year (a "suspension order").

Appeals

20. Pursuant to section 29(1)(i) of the 2002 Act, the decision of the Committee to impose a suspension order is a "relevant decision" within that section. Under section 29(4) of the 2002 Act, the PSA may refer the case to the High Court if it considers that the decision was "not sufficient (whether as to a finding or a penalty or both) for the protection of the public". Section 29(4A) provides that consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient (a) to protect the health, safety and well-being of the public; (b) to

maintain public confidence in the profession concerned; and (c) to maintain proper professional standards and conduct for members of that profession.

21. A referral is treated as an appeal: section 29(7). Under section 29(8), this Court's powers on appeal include the power to dismiss the appeal, to allow the appeal and quash the decision appealed against, to substitute for the decision any other decision which could have been made by the Committee, or to remit the case to dispose of the case in accordance with the Court's directions.

22. An appeal under section 29 is a by way of review, rather than by way of rehearing (see CPR 52.21 (1); Practice Direction 52D §19 does not apply). The question for the Court is whether the decision of the Committee was wrong, or unjust due to serious procedural or other irregularity: see CPR 52.21 (3).

The approach of the court in relaton to this appeal (against sanction)

23. In relation to the approach of this Court to an appeal under section 29, I have considered a number of authorities; in particular *Bolton v Law Society* [1994] 1 WLR 512 at 519B-E; *Council for the Regulation of Healthcare Professionals v GMC and Ruscillo* [2005] 1 WLR 717 at §§71, 73, 76 to 78; *Council for the Regulation of Healthcare Professionals v GMC and Southall* [2005] EWHC 579 (Admin) at §§8 to 11; *Khan v General Pharmaceutical Council* [2007] 1 WLR 169 at §36; *GMC v Boateng* [2017] EWHC 3565 (Admin) at §§13, 50 and 53; *GMC v Theodoropoulos* [2017] 1 WLR 4794 at §§34 (v) to (viii), 36 to 38; *GMC v Khetyar* [2018] EWHC 813 (Admin) at §§20 to 22; *GMC v Bawa-Garba* [2018] 1 WLR 1929 at §67; *Sayer v General Osteopathic Council* [2021] EWHC 370 (Admin) at §24 and *Sastry v GMC* [2012] EWCA Civ 623 at §§97-99, 106-108, 113. From these authorities I draw the following propositions.

(1) The principal purpose of sanctions in disciplinary proceedings is not punishment of the practitioner, but rather maintaining the standards and reputation of the profession as a whole and maintaining public confidence in the integrity of the profession. For this reason, matters of personal mitigation, such as testimonials from fellow professionals and remorse and reform, are of less weight. The reputation of the profession is more important than the fortunes of any individual member: see *Bolton,* supra.

(2) There is a difference between an appeal by a professional/registrant and an appeal by the PSA under section 29. In the latter case the approach of the court is in principle supervisory in nature: *Sastry* §§107 and 108.

(3) In such an appeal, the court should only interfere with the evaluative judgment of a specialist adjudicator if (i) there was an error of principle in carrying out the evaluation; or (ii) it fell outside the bounds of what an adjudicative body could properly and reasonably decide: *Bawa-Garba* at §67 and *Sastry* §108.

(4) In a section 29 appeal specifically, the role of the Court is to consider whether the tribunal has properly performed that task so as to reach a correct decision as to the imposition of a penalty. The issue is likely to be whether the tribunal has reached a decision as to penalty that is manifestly inappropriate having regard to the practitioner's conduct and the interests of the public. Where all material evidence

has been placed before the disciplinary tribunal and it has given due consideration to the relevant factors, the Court should place weight on the expertise brought to bear in evaluating how best the needs of the public and the profession should be protected. Where, however, there has been a failure of process, or evidence is taken into account on appeal that was not placed before the disciplinary tribunal, the decision reached by that tribunal will inevitably need to be reassessed: *Ruscillo*, supra.

(5) Where the misconduct relates to professional performance, the expertise of the tribunal is likely to carry greater weight. However, where the misconduct does not relate directly to professional performance standards, for example, cases of dishonesty or sexual misconduct, the Court is well placed to assess what is needed to protect the public, maintain the reputation of the profession or maintain public confidence in the profession and may attach less weight to the expertise of the tribunal: *Southall* §11, *Khan* §36, *Boateng* §13, *Sastry* §§106, 113. This approach goes beyond sexual misconduct and dishonesty, and extends more generally to matters not related to professional performance; see *Khan* §36. In my judgment, this approach therefore applies in the present case to the findings of assault, as well as to the findings of dishonesty.

(6) Honesty and integrity are fundamental in relation to qualifications and the system of applying for medical positions. Where a doctor engages in deliberate dishonesty and lacks insight into that dishonesty, erasure may, in practical terms, be inevitable: *Theodoropoulos §*§36, 38.

(7) As regards the sanctions guidance provided by the professional body itself, it is an authoritative steer for tribunals as to what is required to protect the public, even if it does not dictate the outcome; it is an authoritative steer as to the application of the principle of proportionality. If the tribunal departs from the steer given by the Guidance, it must have careful and substantial case-specific justification. A generalised assertion that erasure or striking off would be disproportionate and that the conduct was not incompatible with continued registration will be inadequate and will justify the conclusion that the tribunal has not properly understood the gravity of the case before it: see Khetyar §§21 and 22.

(8) Even where guidance directs a tribunal to consider sanctions "from the bottom up" (i.e starting with the least restrictive), a proper conclusion that suspension is sufficient cannot be reached without careful consideration of the guidance in relation to the more serious sanction of erasure: *Khetyar* §§20.

The approach to rejected defence and lack of insight

24. As regards the relationship between contesting the charges and insight, I have considered *Sayer*, supra at §25 (where I reviewed the then previous authorities) and the recent case of *Sawati v GMC* [2022] EWHC 283 (Admin) at §§75 to 110 (where Collins Rice J considered all previous authorities, including those following *Sayer*). In *Sayer* I set out the following principles (cited in *Sawati* at § 94):

(1) Insight is concerned with future risk of repetition. To this extent, it is to be distinguished from remorse for the past conduct.

(2) Denial of misconduct is not a reason to increase sanction.

(3) It is wrong to equate maintenance of innocence with lack of insight. Denial of misconduct is not an absolute bar to a finding of insight. Admitting misconduct is not a condition precedent to establishing that the registrant understands the gravity of the offending and is unlikely to repeat it.

(4) However attitude to the underlying allegation is properly to be taken into account when weighing up insight. Where the registrant continues to deny impropriety, that makes it more difficult for him to demonstrate insight. The underlying importance of insight and its relationship with denial of misconduct was usefully analysed by Andrew Baker J in *Khetyar* (at §49) as follows:

> "Of course, no sanction was to be imposed on him for his denials as such; however, insight requires that motivations and triggers be identified and understood, and if that is possible at all without there first being an acceptance that what happened did happen it will be very rare, and any assessment of ongoing risk must play close attention to the doctor's current understanding of and attitude towards what he has done."
>
> (emphasis added)

(5) The assessment of the extent of insight is a matter for the tribunal, weighing all the evidence and having heard the registrant. The Court should be slow to interfere.

25. In *Sawati* Collins Rice J undertook a more thorough review of the issue. She observed that reconciling the principle of due process and the principle of protecting the public from practitioners, who cannot accept findings of fault and are at risk of repeating their failing, may be difficult in an individual case and is fact sensitive. She then went on to identify a number of factors, relevant to that reconciliation, at §§ 104 to 108 and concluded at §§109 to 110:

> "In short, before a Tribunal can be sure of making fair use of a rejected defence to aggravate sanctions imposed on a doctor, it needs to remind itself of Lord Hoffmann's starting place that doctors are properly and fairly entitled to defend themselves, and may then find it helpful to think about four things: (i) how far state of mind or dishonesty was a primary rather than second-order allegation to begin with (noting the dangers of charging traps) – or not an allegation at all, (ii) what if anything the doctor was positively denying other than their own dishonesty or state of knowledge; (iii) how far 'lack of insight' is evidenced by anything other than the rejected defence and (iv) the nature and quality of the defence, identifying clearly any respect in which it was itself a deception, a lie or a counter-allegation of others' dishonesty.
>
> These are all evaluative matters. Tribunals need to make up their own minds about them, and their relevance and weight, on the facts they have found. But they do need to direct their

> minds to the tension of principles which is engaged, and check they are being fair to both the doctor and the public. They need to think about what they are doing before they use a doctor's defence against them, to bring the analysis back down to its simplest essence."

26. The present case is somewhat different. Here it is not said that there was lack of insight due to denial of the charges. The issue, if any, is whether the Committee's findings of insight (in relation to the assault) and potential insight (in relation to dishonesty) adequately took account of the Registrant's denials.

Sanctions Guidance

27. The NMC Sanctions Guidance is in a number of parts. First, SAN-1 provides, inter alia, as follows:

> "**Factors to consider before deciding on sanctions**
>
> …
>
> **Proportionality**
>
> Being proportionate means finding a fair balance between the nurse or midwife's rights and our overarching objective of public protection. We need to choose a sanction that doesn't go further than we need to meet this objective. This reflects the idea of right-touch regulation, where the right amount of "regulatory force" is applied to deal with the target risk, but no more.
>
> …
>
> To be proportionate, and not go further than it needs to, the Committee should think about what action it needs to take to tackle the reasons why the nurse or midwife is not currently fit to practise.
>
> They should consider whether the sanction with the least impact on the nurse or midwife's practice would be enough to achieve public protection, looking at the reasons why the nurse or midwife isn't currently fit to practise and any aggravating or mitigating features.
>
> If this sanction isn't enough to achieve public protection, they should consider the next most serious sanction. When the Committee finds the sanction that is enough to achieve public protection, then it has gone far enough.
>
> <u>They need to explain why the following most serious sanction is not necessary as it would be going further than is needed to achieve public protection - simply saying that it would be disproportionate isn't enough</u>.

Aggravating features

…

Some potentially aggravating features are:

- Any previous regulatory or disciplinary findings
- abuse of a position of trust
- lack of insight into failings
- a pattern of misconduct over a period of time
- conduct which put patients at risk of suffering harm.

If a nurse or midwife's actions put people at risk of being harmed, this risk makes their case more serious. …

…

Mitigating features

…

Mitigation can be considered in three categories.

- Evidence of a nurse or midwife's insight and understanding of the problem, and their attempts to address it. This may include early admission of facts, apologies to anyone affected, any efforts to prevent similar things happening again, or any efforts to put problems right.

- Evidence of that the nurse or midwife's has followed the principles of good practice. This may include … their previous good character or history.

- Personal mitigation, such as periods of stress or illness, personal and financial hardship, level of experience at the time in question and the level of support in the workplace.

In regulatory proceedings, where the purpose of sanctions is to protect the public and not to punish nurses and midwives, personal mitigation is usually less relevant than it would be to punishing offenders in the criminal justice system. In some cases, sanctions might have an effect that could be described as being punitive, but this is not their purpose.

As we explained in the section about aggravating factors, we take patient harm extremely seriously. Putting patients at risk of harm makes a nurse or midwife's failings more serious. If the

nurse or midwife's actions put patients or members of the public at a real risk of suffering harm, and the reason they did not suffer harm was down to chance, the fact that nobody suffered actual harm is generally not a good mitigating factor.

Nurses and midwives can submit references and testimonials as mitigation evidence. The Fitness to Practise Committee will use our guidance on remediation and insight when weighing up how useful these documents are to their decision making in each case.

…

Previous fitness to practise history

…

The fact that a nurse or midwife does not have a past fitness to practise history is not generally a relevant consideration to the decision on sanction. Unlike a criminal court, the panel is not punishing the nurse or midwife. Its role is to decide which sanction is needed to achieve public protection. This includes protecting patients, maintaining public confidence and upholding the standards we expect of nurses and midwives.

…

Sometimes panels will have to make decisions on sanction in cases where the nurse or midwife's conduct is so serious that it is fundamentally incompatible with continuing to be a registered professional. If this is the case, the fact that the nurse or midwife does not have any fitness to practise history, cannot change the fact that what they have done cannot sit with them remaining on our register.

For these reasons, panels should bear in mind there will be usually be only extremely limited circumstances where the concept of a "previously unblemished career" will be a relevant consideration when they are deciding which sanction is needed, or in giving their reasons."

(emphasis added)

28. Secondly, SAN-2 of the Sanctions Guidance provides as follows:

"**Considering sanctions for serious cases**

In this guide

- How we determine seriousness
- Cases involving dishonesty
- Cases involving sexual misconduct

- Cases involving criminal convictions or cautions

How we determine seriousness

Our guidance on seriousness explains that there are certain concerns that are more difficult to put right and often mean that the nurse or midwife's right to practise needs to be restricted.

In cases involving dishonesty, sexual misconduct and criminal convictions or cautions, it's likely that we would need to take action to uphold public confidence in nurses and midwives, or to promote proper professional standards.

The guidance below covers the considerations a panel should make when reviewing these types of cases and deciding which sanction to impose.

There's further guidance on factors to consider before deciding on sanctions.

Cases involving dishonesty

The most serious kind of dishonesty is when a nurse or midwife deliberately breaches the professional duty of candour to be open and honest when things go wrong in someone's care.

However, because of the importance of honesty to a nurse or midwife's practice, dishonesty will always be serious.

In every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse or midwife should be allowed to remain on the register will involve:

- deliberately breaching the professional duty of candour to cover up when things have gone wrong, especially if it could cause harm to patients
- misuse of power
- vulnerable victims
- personal financial gain from a breach of trust
- direct risk to patients
- premeditated, systematic or longstanding deception

Dishonest conduct will generally be less serious in cases of:

- one-off incidents
- opportunistic or spontaneous conduct
- no direct personal gain
- no risk to patients

- incidents in private life of nurse or midwife

The law about healthcare regulation makes it clear that a nurse or midwife who has acted dishonestly will always be at risk being removed from the register.

Nurses and midwives who behaved dishonestly can engage with the Fitness to Practise Committee to show that they feel remorse, that they realise they acted in a dishonest way, and tell the panel that it will not happen again. … . If they do this, they may be able to reduce the risk that they will be removed from the register.

None of this means that the Fitness to Practise Committee only has choice between suspending a nurse or midwife or removing them from the register in cases about dishonesty. It's vital that, like any other case, the Fitness to Practise Committee should start by considering the sanction with the least impact on the nurse or midwife's practice, and work upwards to the next most serious sanctions if it needs to."

(emphasis added)

29. In the next section – SAN 3 - the Sanctions Guidance lists, and deals in turn with, each of the available sanctions. Suspension orders and strike-off orders are dealt with as follows:

"**Suspension order**

This order suspends the nurse or midwife's registration for a period of up to one year and may be appropriate in cases where the misconduct isn't fundamentally incompatible with the nurse or midwife continuing to be a registered professional, and our overarching objective may be satisfied by a less severe outcome than permanent removal from the register.

…

Key things to weigh up before imposing this order include:

- whether the seriousness of the case require temporary removal from the register?
- will a period of suspension be sufficient to protect patients, public confidence in nurses and midwives, or professional standards?

Use the checklist below as a guide to help decide whether it's appropriate or not. This list is not exhaustive:

- …

- no evidence of harmful deep-seated personality or attitudinal problems
- no evidence of repetition of behaviour since the incident
- the Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour

…

When considering seriousness, the Fitness to Practise Committee will look at how far the nurse or midwife fell short of the standards expected of them. It will consider the risks to patients and to the other factors above, and any other particular factors it considers relevant on each case.

When making a suspension order the Fitness to Practise Committee may wish to explain clearly what expectations it has, or what actions the nurse or midwife could take that would help a future Committee reviewing the order before it expires.

Striking-off order

A striking-off order is the most serious sanction. It results in removing the nurse or midwife's name from the register, which prevents them from working as a registered nurse or midwife.

This sanction is likely to be appropriate when what the nurse or midwife has done is fundamentally incompatible with being a registered professional. Before imposing this sanction, key considerations the panel will take into account include:

- Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?
- Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?
- Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?

The panel should refer to our guidance on seriousness, which highlights a number of factors indicating which kinds of concern it may not be possible for the nurse or midwife to remedy or put right, and which will most seriously affect their trustworthiness as a registered nurse or midwife.

The courts have supported decisions to strike off healthcare professionals where there has been lack of probity, honesty or trustworthiness, notwithstanding that in other regards there were no concerns round the professional's clinical skills or any risk of harm to the public. Striking-off orders have been upheld

> on the basis that they have been justified for reasons of maintaining trust and confidence in the professions.
> …"
>
> (emphasis added)

The "guidance on seriousness" referred to in the above section is to be found within the NMC's guidance on fitness to practise, to which I now turn.

The Fitness to Practise Guidance

30. On the NMC website there is a "Fitness to Practise Library". One of the 11 items there listed is entitled "Understanding Fitness to Practise". Within that title, there are 40 numbered individual guides. In the following paragraphs I refer to five of these "guides", three of which address "seriousness". The first, FTP-3, is as follows:

> "**How we determine seriousness**
>
> In this guide
>
> - What we mean by seriousness
> - Factors that indicate the seriousness of a case
>
> …
>
> **What we mean by seriousness**
>
> Seriousness is an important concept which informs various stages of our regulatory processes.
>
> When assessing whether a concern is serious, we look at what risks are likely to arise if the nurse, midwife or nursing associate doesn't address or put this concern right. This could be risks to patients or service users or, in some cases, to the public's trust and confidence in all nurses, midwives and nursing associates.
>
> When considering seriousness, we will take into account evidence of any relevant contextual factors. For more information please see our guidance on taking account of context.
>
> …
>
> **Factors that indicate the seriousness of a case**
>
> Decision makers across our fitness to practise process look at factors of a case to identify the types of concern which, unless put right, will usually mean a nurse, midwife or nursing associate's right to practise needs to be restricted.
>
> These factors indicate the seriousness of the case and we use these as a framework for the way we investigate cases and

present cases before panels of the Fitness to Practise Committee.

The factors can be broken down into three broad categories:

- Serious concerns which are more difficult to put right
- Serious concerns which could result in harm to patients if not put right
- Serious concerns based on the need to promote public confidence in nurses, midwives and nursing associates

…" (emphasis added)

31. The second "guide" (FTP-3a) states as follows:

"**Serious concerns which are more difficult to put right**

…

A small number of concerns are so serious that it may be less easy for the nurse, midwife or nursing associate to put right the conduct, the problems in their practice, or the aspect of their attitude which led to the incidents happening.

…

We will need to do this where the evidence shows that the nurse, midwife or nursing associate is responsible for:

…

- deliberately causing harm to patients
- deliberately using false qualifications or giving a false picture of employment history which hides clinical incidents in the past, not telling employers that their right to practise has been restricted or suspended, practising or trying to practise in breach of restrictions or suspension imposed by us

…"

32. The third "guide" (FTP-3c) provides, inter alia, as follows:

"**Serious concerns based on public confidence or professional standards**

…

We may need to take restrictive regulatory action against nurses, midwives or nursing associates whose conduct has had this kind of impact on the public's trust in their profession, who haven't made any attempt to reflect on it, show insight, and haven't taken any steps to put it right. This may mean they can't stay on the register.

…." (emphasis added)

33. The fourth "guide" (FTP-13a) provides, inter alia, as follows:

"**Can the concern be addressed?**

…

Decision makers should always consider the full circumstances of the case in the round when assessing whether or not the concerns in the case can be addressed. This is true even where the incident itself is the sort of conduct which would normally be considered to be particularly serious.

The first question is whether the concerns can be addressed. That is, are there steps that the nurse, midwife or nursing associate can take to address the identified problem in their practice?

…

Decision makers need to be aware of our role in maintaining confidence in the professions by declaring and upholding proper standards of professional conduct. Sometimes, the conduct of a particular nurse, midwife or nursing associate can fall so far short of the standards the public expect of professionals caring for them that public confidence in the nursing and midwifery professions could be undermined. In cases like this, and in cases where the behaviour suggests underlying problems with the nurse, midwife or nursing associate's attitude, it is less likely the nurse, midwife or nursing associate will be able to address their conduct by taking steps, such as completing training courses or supervised practice.

Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:

…

- dishonesty, particularly if it was serious and sustained over a period of time, or directly linked to the nurse, midwife or nursing associate's practice
- violence, neglect or abuse of patients.

…." (emphasis added)

34. The fifth "guide" (FTP-13b) provides inter alia as follows:

"**Has the concern been addressed?**

…

Demonstrating insight

Before effective steps can be taken to address concerns, the nurse, midwife or nursing associate must recognise the problem that needs to be addressed. Therefore insight on the part of the nurse, midwife or nursing associate is crucially important.

A nurse, midwife or nursing associate who shows insight will usually be able to:

- step back from the situation and look at it objectively
- recognise what went wrong
- accept their role and responsibilities and how they are relevant to what happened
- appreciate what could and should have been done differently
- understand how to act differently in the future to avoid similar problems happening.

Decision makers do more than simply look at whether a nurse, midwife or nursing associate has shown 'any' insight or not. They need to assess the quality and nature of the insight. There may still be a public interest in restricting a nurse, midwife or nursing associate's right to practise, even if they have shown 'some' insight into what happened.

Where a panel has found that a nurse, midwife or nursing associate was responsible for incidents that they denied (or continue to deny), this should not bar the nurse, midwife or nursing associate from being able to show insight. They may not have insight into the particular events that occurred, but they may be able to show insight by having an understanding of the need to minimise the risk of similar events occurring in the future, and the steps that might be taken to achieve this.

Assessing whether insight is sufficient

It is important to carefully assess whether the insight shown by the nurse, midwife or nursing associate is enough to address the specific concerns that arise from their past conduct, rather than simply identifying whether 'any' or 'some' evidence of insight is present. What is sufficient insight will depend on the circumstances of the case.

Decision makers must always consider each case on its own facts and circumstances. However, the following factors will be useful when considering whether the evidence of insight is sufficient to address the concerns in the case.

- If they had the opportunity to do so, did the nurse, midwife or nursing associate cooperate with their employer's or any other local investigation into the concerns?
- Did the nurse, midwife or nursing associate accept the concerns against them when first raised by their employer?

…

- Does the nurse, midwife or nursing associate accept the substance of our regulatory concern, and accept responsibility for any failings or inappropriate conduct?
- Has the nurse, midwife or nursing associate done so since the early stages of our investigation?
- Does the nurse, midwife or nursing associate acknowledge:
    - any harm or risk of harm, to patients?
    - any damage to public confidence in the professions?
    - how far their conduct or practice fell short of professional standards?
    - their own responsibility for the problem, without seeking to blame others or excuse their actions?

If a nurse, midwife or nursing associate shows insight when they had previously not accepted responsibility for their actions, decision makers should consider this carefully. They should assess whether it was possible for the nurse, midwife or nursing associate to make admissions earlier on by considering the information that was given to the nurse, midwife or nursing associate during their employer's investigation, other earlier local investigations, or our own investigation.

…

Sufficient steps to address the concern

…

Key considerations for decision makers in assessing the steps taken by a nurse, midwife or nursing associate to address concerns in their practice will be whether the steps taken are:

- relevant, in that they are directly linked to the nature of the concerns
- measurable (for example, where the nurse, midwife or nursing associate says they have been on a training course, information should be provided to help the decision maker understand the scope of the course, the topics covered and the results of any assessments)

- effective, addressing the concerns and clearly demonstrating that past failings have been objectively understood, appreciated and tackled.

Sufficient and appropriate steps may include the following.

- Attending a training course. Decision makers should assess whether the course content is relevant to the concerns in the case and whether the course was sufficiently comprehensive, ideally including a practical element and some form of assessment, with results available.
- Reflection. Reflective work by the nurse, midwife or nursing associates will be of more weight where they are able to give examples not only of what they have learned following the concerns being raised, but also how they have applied this learning in their practice.

_____

…." (emphasis added)

The Tribunal proceedings

The allegations

35. The charges against the Registrant stated as follows:

"1. On or around 11 March 2020 while Patient A was restrained on the floor:

a) thrust a chair at Patient A's head;

b) Kicked patient A in the head one or more times.

2. Failed to disclose on an application form to Homerton University Hospital dated 30 April 2020 that you had been employed by Cygnet Health Care.

3. On 19 May 2020, during an interview at Homerton University Hospital, failed to declare that you had been dismissed from your employment with Cygnet Health Care.

4. Failed to disclose on a declaration form dated 21 May 2020 that you had been dismissed by Cygnet Health Care.

5. Worked on 4th and/or 5th July 2020 as a registered nurse in breach of an interim order (IO) in that you:

a) worked for Day Webster when your practice had been confined to working for Trust Care Solutions Ltd and Pertemps Medical Professionals;

b) failed to ensure that you were supervised whilst working as a nurse.

6. Breached your conditions of practise order in that you failed to disclose your conditions of practise immediately, or at all, to:

a) Day Webster Group;

b) Homerton University Hospital.

7. Your conduct in Charges 2, and/or 3 and/or 4 and/or 6b was dishonest in that you deliberately sought to mislead Homerton University Hospital by withholding this information.

8. Your conduct in charge 6a was dishonest in that you deliberately sought to mislead Day Webster Group by withholding this information.

AND in light of the above, your fitness to practise is impaired by reason of your misconduct."

The hearing and the evidence

36. The hearing before the Committee took place on 7 days between 9 and 17 January 2023. The fact-finding stage took 5 days. The Committee considered documents and statements filed by both parties. The Committee received written and oral evidence from the Registrant and oral evidence from five witnesses called by the NMC, including from "Mr 1", a healthcare support assistant at the Hospital who was present during the incident on 11 March 2020.

37. On 13 January 2023 the Committee handed down its decision on the facts. On 16 January 2023 the Committee heard submissions, and handed down its decision on misconduct and impairment. On 17 January 2023 the Committee heard submissions, and handed down its decision on sanction. The Decision document itself contains the Committee's determinations on the facts, and on misconduct and impairment and on sanction.

38. In her oral evidence, the Registrant described Patient A hitting her. She said it was her responsibility to coordinate the restraint to make sure that the patient was safe. She expressly denied that she had thrust a chair at Patient A's head and that she at any time kicked Patient A in the head. She denied stamping on Patient A. She confirmed as true her evidence, given earlier at the investigation meeting on 6 April 2020, that she had not touched the patient and that she had not kicked. She added that she was frightened and she was traumatised because she had already been attacked by a chair. In cross-examination in relation to Patient A's letter, she said that the handwriting was not his and the letter was written for him for the investigation. When pressed she said "yes he was making it up because he was spoon-fed by the staff". In re-examination she maintained her claim that there were staff behind the letter.

39. As regards the suggestion that at the time of the incident, the question of giving medication to Patient A arose, Mr 1 had said in his evidence in chief that once the patient was on the floor it would be the other team - the nursing team - which would decide whether the patients require medication to manage the agitation, and decide whether to offer oral or intravascular injection.

40. The Registrant provided evidence of training by way of certificates. She attended and completed a one-day refresher programme on restraint techniques on 5 October 2020 and on basic life support and moving and handling on 6 October 2020. She attended and completed a one day refresher course on restraint techniques again on 2 October 2021 and again on 30 September 2022. She provided "reflection" statements on a number of occasions, the last being dated 20 November 2021.

The Decision

41. The Decision is in a number of parts. First, the Committee set out its findings of fact in relation to the allegations.

The findings of fact

42. In summary, the Committee found as follows:

- Charges 4 and 5(a) were admitted
- Each of charges 1(a) and (b), 2, 6(a) 7 (in relation to charges 2 and 4) proved
- Charges 3, 5(b), 6(b) and 8 not proved.

43. In relation to charge 1(a) the Committee recorded that at the investigatory meeting the Registrant had said that she was giving the chair to another nurse and denied using it to thrust at Patient A. That evidence was repeated before the Committee. Her explanation was inconsistent with the CCTV footage. The Committee concluded that "while Patient A was restrained on the floor, you thrust a chair at Patient A's head".

44. In relation to charge 1(b), the Committee recorded that, in oral evidence, the Registrant denied kicking or stamping in the direction of Patient A's head and said that she was pulling her leg away from Patient A. In relation to the first alleged kick, the Committee could not see from the CCTV whether the Registrant's foot impacted Patient A's head. However in relation to the slightly later footage, the Committee concluded that the Registrant can be seen kicking in the direction of Patient A's head. It found that the Registrant's explanation was inconsistent with the CCTV footage and preferred the evidence of Mr 1 (namely, that the Registrant had kicked or stamped Patient A in the head). The Committee concluded that it was clear that the Registrant had propelled her foot towards Patient A's head and it was immaterial whether it was a kick or a stamp. Patient A would not necessarily have been able to register what type of impact it was. Further the Committee was satisfied that the Patient A's letter of complaint broadly supported the evidence of Mr 1 and the CCTV footage. The Committee concluded that "while Patient A was restrained on the floor, you kicked Patient A in the head one or more times."

45. In relation to charge 6(a), the Committee concluded that the Registrant had not sent the Interim Order to Day Webster when she had received it but had attempted to send it one week later. Whilst typing the email address for Day Webster incorrectly was

understandable, the Committee considered that the Registrant had a responsibility to inform Day Webster and that she had not done this. There was no evidence that the Registrant made a further attempt to inform Day Webster of the Interim Order. However, in relation to charge 8, the Committee found that this failure to inform Day Webster was not intended to mislead and thus was not dishonest.

46. In relation to charge 6(b), the Committee concluded that, because of the precise terms of condition 6(a) of the Interim Order, the Registrant was under no obligation to inform the Trust rather than Day Webster on the basis that she was working bank shifts with the Trust through her agency, Day Webster. On that basis this charge was found not proved.

47. In relation to charge 7, and charge 2, the Committee "was satisfied that your intention was to mislead Homerton Hospital in order that you could secure a bank position" and that the Registrant was dishonest. Similarly, in relation to charge 4 (the Declaration Form) the Committee did not accept the Registrant's explanation that she had drafted the form before receiving the letter of dismissal. The Committee was of the view that "you intentionally attempted to mislead Homerton University Hospital to secure a bank position" and that her actions were dishonest.

Misconduct and Impairment

48. Following the further hearing, on 16 January 2023 the Committee made the determination on misconduct and impairment.

Misconduct

49. The Committee addressed misconduct at pages 33 to 36 of the Decision. It concluded that charges 1, 2, 4 and 7 (in respect of charges 2 and 4) amounted to misconduct. However, the Committee found that charges 5(a) and 6(a) were not sufficiently serious to amount to misconduct. It considered the errors to be "administrative mistakes and misunderstandings". However its consideration of charge 5(a) was confused and, in my judgment, erroneous. The Committee appeared to consider that charge 5(a) related to condition 6 of the Interim Order, rather than breach of condition 1. As a result the Committee did not expressly consider whether the *admitted* breach of condition 1 (i.e. confining practice to working for the two named agencies) amounted to misconduct.

50. The Committee found that the Registrant's actions fell significantly short of the standards expected of a nurse and that her actions amounted to a breach of "The Code: professional standards of practice and behaviour for nurses and midwives" ("the Code"). After referring to paragraphs 1, 20 and 23 of the Code the Committee noted that there were three areas of concern, namely the incident with Patient A; dishonesty relating to the job application; and breaching of the Interim Order.

51. In relation to the incident with Patient A, the Committee stated:

> "It bore in mind that Patient A had struck you prior to the hospital staff restraining him and consider that your reaction, in the fast moving events covered in charges 1 (a) and 1 (b) was a reaction to this. However, the panel considered that there still

> would have been an expectation for a nurse of your standing and experience, to control your reaction and remain professional."

The Committee pointed out that the Registrant was the nurse in charge during the incident and concluded that "your actions in this case were deplorable and a serious departure from the standards expected of a registered nurse".

52. In relation to the dishonesty, the Committee considered this to be a serious failing. It concluded that "your actions fell significantly short of the conduct and standard expected of a nurse to amount to serious misconduct".

Impairment

53. The Committee addressed impairment at pages 36 to 41 of the Decision. In summary, in respect of charges 1(a) and (b), the Committee decided that a finding of impairment was not necessary on grounds of public protection. However, in respect of charges 2, 4 and 7 a finding of impairment was necessary on public protection grounds. Further in respect of all the charges found to be misconduct, a finding of impairment was required to promote and maintain public confidence in the profession and uphold professional standards for members of the profession. In this way the Registrant's fitness to practise was found to be impaired by reason of each of the established charges.

54. The Committee commenced by stating as follows:

> "Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession."

55. As regards the assault, the Committee concluded that the Registrant had in the past acted so as to put Patient A as an unwarranted risk of harm. In its judgment, the public did not expect a nurse to act as she did as they require nurses to adhere at all times to the appropriate professional standards and to safeguard the health and well-being of patients. Then, as regards dishonesty, the Committee was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

56. The Committee continued that it had to make a current assessment of fitness to practise and that involved taking account of what had happened since the misconduct, and whether the concerns identified were capable of remediation, whether they had been remedied and whether there was a risk of repetition in the future. The Committee had therefore considered both the nature and extent of both elements of misconduct and whether the Registrant had provided sufficient evidence of insight and remorse.

57. Turning to the assault, the Committee stated:

> "Regarding insight, in relation to [the assault], the panel took account of your reflective statements. It noted that you have expressed remorse for the incident, have undertaken relevant training and have had no repetition in the more than two years of work since the incident as shown by numerous testimonies from colleagues and line managers. The panel also noted that you stated, in your reflective statement, that your GP has referred you to cognitive behavioural therapy. You stated:
>
> > "… I engaged with the service and have found it very useful especially as that you have engaged with this and found it useful and it gives me a registered practitioner an opportunity to see treatment from the patient's perspective. I feel I am in a much better position now to deal with patients if I found myself in a similar situation…"
>
> The panel was satisfied that you demonstrated sufficient insight into these failings."

58. On this basis the Committee concluded that the concerns arising from the assault were capable of remediation. In considering whether or not she had remedied her practice, it took account of the training certificates and the numerous testimonials which attested to her professionalism, her willingness to lead, to support staff and her kindness towards patients. The Committee continued as follows:

> "The panel is encouraged by your professional development since the incident on 11 March 2020. The panel is satisfied that you have taken steps to address your failings and have demonstrated strengthened practice. The panel also took into account that you have been working since these incidents occurred and it was satisfied that there is no evidence to suggest that your misconduct will be repeated.
>
> In light of your steps taken to strengthen your practice through training and clinical supervision, the positive feedback from colleagues and the fact that you are currently working without incident, the panel decided that a finding of impairment is not necessary on the grounds of public protection with regards to charges 1 (a) and 1 (b)".

In this way, the Committee appears to have concluded that it was satisfied that there was no substantial risk of a repetition of the assault.

59. The Committee then turned to consider the issue of remediation in relation to *dishonesty*, stating that dishonesty is often said to be less easily remediable than other kinds of conduct. The Committee stated:

> "While the panel found two instances of dishonesty relating to your job application, it noted that it had no evidence before it to

> suggest that this had happened before or since. The panel was satisfied that this was a one-off incident."

In relation to insight, the Committee noted that the Registrant's reflective statement did not address the impact that her dishonesty had had on colleagues and in bringing the nursing profession into disrepute. "As a result, the panel determined that you had demonstrated insufficient insight on this matter". The Committee continued:

> "Although the panel did not find a deep-seated attitudinal problem in your case, the lack of sufficient insight into your dishonesty indicated that there is a risk of repetition. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection."

60. Finally, turning to consider the overriding objectives of the NMC and in particular public confidence and upholding professional standards, the Committee made a finding of current impairment on grounds of upholding proper professional standards and public confidence in respect of both the assault and the dishonesty. It concluded that:

> "Your fitness to practise is currently impaired by reason of misconduct on public interest grounds".

Sanction

61. At pages 41 to 51 of the Decision, the Committee then proceeded to the sanction stage. After recording the parties' submissions, at pages 44 to 49, it set out its "Decision and reasons on Sanction".

62. The Committee started by stating that it had had careful regard to the Sanctions Guidance and that the decision was a matter for the panel independently exercising its own judgment. The Committee went on:

> "The panel took into account the following aggravating features:
>
> - Your conduct placed a vulnerable patient at a risk of harm whilst they were under your authority as the Nurse in Charge;
> - There was a personal interest by not declaring your most recent employer on your application form.
>
> With regards to the dishonesty found in this case, the panel had regard to the NMC Guidance "Considering sanctions for serious cases" (Reference: SAN-2), which stated:
>
> *"…In every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct. Not all dishonesty is equally serious…"*

> The panel noted that your dishonesty in this case placed patients and colleagues at indirect risk. It considered that by depriving your employers of important information, they were unable to put mechanisms in place to support you and protect patients.
>
> However, the panel reminded itself that while it had found two instances of dishonesty relating to your job application, it noted that it had no evidence before it to suggest that this had happened before or since. It noted that this was not a longstanding deception and bore in mind that the numerous testimonials you provided suggest that this was out of character for you.
>
> In light of the above, the panel determined that your dishonesty in this case was not at the upper end of the spectrum of seriousness.
>
> The panel also took into account the following mitigating features:
>
> - A 30-year unblemished career in healthcare;
> - A single instance of dishonest conduct;
> - Positive steps taken to remediate the concerns pertaining to the March 2020 incident;
> - Your insight into the March 2020 incident demonstrated an ability to reflect that can be applied to the outstanding issues;
> - Numerous testimonials from colleagues, your current line manager and supervisor;
> - You have worked with the same employer for a year with no concerns raised;
> - No previous regulatory history.
>
> The panel also took account of the personal mitigation raised by Mr Buxton in his submissions pertaining to the financial aid you provide for the care of your son, although noted that personal mitigation carries less weight in regulatory than in criminal cases." (emphasis added)

63. The Committee then, in turn, considered as possible sanctions: no action, a caution order, a conditions of practice order. It rejected each. The Committee then continued.

> "The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that

suspension order may be appropriate where some of the following factors are apparent:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel found no evidence of harmful deep-seated personality or attitudinal problems in your case. There has been no repetition of the behaviour since the incident and the panel was satisfied that you demonstrated remorse into your misconduct and evidence of reflection that the likelihood of repetition is low. While you have not yet demonstrated insight into the dishonesty, the panel decided that you show potential to do so if given an opportunity.

In light of the above, the panel considered that your misconduct was not fundamentally incompatible with your remaining on the register and that the public interest could be marked by a suspension order.

The panel did go on to consider whether a striking-off order would be proportionate but, taking into account all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive impact, it would be unduly punitive in your case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of 12 months is appropriate and proportionate in this case to mark the seriousness of your misconduct. It also considered that this period of suspension would allow you time to sufficiently

> reflect on the impact your dishonesty had on patients, colleagues and the nursing profession.
>
> The panel determined that a suspension order, unlike a striking off order, would also provide the opportunity to return an otherwise experienced nurse with a previously unblemished record to practice. It considered that it is in the public interest to return nurses to the Register where possible.
>
> At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.
>
> …" (emphasis added)

The Appeal

The grounds of appeal

64. The PSA puts forward five grounds of appeal as follows:

(1) The Committee erred in finding (i) that the Registrant had demonstrated sufficient insight into the assault and/or (ii) that a finding of impairment was not necessary on public protection grounds and/or (iii) that there was "no evidence" of harmful deep-seated personality or attitudinal problems.

(2) The Committee erred in its assessment of the seriousness of the Registrant's misconduct.

(3) The Committee was wrong to find allegation 6(b) not proved.

(4) The Committee was wrong to find that the breaches of the Interim Order that were found proved (allegations 5(a) and 6(a)) did not amount to misconduct.

(5) The Committee failed to give adequate reasons for its decision.

65. The NMC supported the PSA's position, pointing out that the assault involved the use of a foot and a chair, as a weapon, and emphasising the fundamental incompatibility of the Registrant's conduct.

The Registrant's position

66. The Registrant in oral argument, made an emotional address to the court. She explained that she has been in the profession for 40 years. She is a mental health nurse, partly because she herself has a child in care, which is challenging. She has loved her job; it was her passion. She asked the Court to show mercy and give her another chance. Striking her off would make her destitute. She had made her reflective statements and has had training. She was practising since the incident between 2020 and 2023 and nothing untoward had occurred; the hospitals where she worked had given her references. She was working at Barnet and Enfield until 16 January.

67. As regards the incident on 11 March 2020, she told the Court that she was on shift and in charge. There had already been a serious incident with Patient A on the day. She seemed to suggest that in the de-escalation room in the CCTV footage, Patient A was being given medication. However when I pressed her about this she did not answer my question about whether that happened in the course of the CCTV footage or after. In fact the evidence is that medication was dealt with later, after the incident. I found her to be evasive on this subject; she appeared still not to accept or be able to explain the kick or what happened with the chair. I have also considered in detail her reflective statements and the many testimonials which speak highly of her and her practice.

The PSA's case in more detail

68. In oral argument, Mr Mant for the PSA put ground (2) ahead of ground (1).

Ground (2): seriousness of misconduct

69. The PSA submits that the Committee were wrong to find that the Registrant's conduct was not fundamentally incompatible with continued registration and that striking off would be disproportionate (even accepting its findings on insight and mediation). The Committee made two errors.

70. First, the Committee mischaracterised the conduct, failing to identify key aggravating features and erring in its identification of mitigating features. As regards the assault, the Committee's descriptions of the assault significantly underplayed the gravity of the Registrant's actions. Moreover the Committee made no mention of other features of the assault. As regards the dishonesty, the Committee's reasons for finding that the dishonesty was not at the upper end of the spectrum of seriousness are flawed. Further the Committee erred by treating the assault and dishonesty as separate. Only one of the mitigating factors related to the inherent seriousness of the conduct. The other mitigating factors were all personal mitigation, which should have been given limited weight.

71. Secondly, the Committee failed to appreciate the profound impact that such conduct has on public confidence. The conduct was likely significantly to harm public confidence in the profession. The Committee failed to address whether suspension was sufficient. The Committee wholly failed to address the guidance at FTP-3a. Where conduct has an impact on public confidence, matters of personal mitigation should be given limited weight. The Committee's stated reasons indicate a clear failure to follow these principles. None of its stated reasons touch on the inherent seriousness of the underlying conduct or its impact on public confidence.

Ground (1): insight, impairment, personality problems

72. The PSA submits that the Committee's assessment of the Registrant's attitude and insight was manifestly wrong. Contrary to the finding of no evidence, there was at least some evidence of a deep-seated personality or attitudinal problem. Further, the finding that the Registrant had sufficient insight was unsustainable. The Court can and should interfere because there are basic flaws in the Committee's logic. First, insight requires that motivations and triggers are understood; secondly, there was no evidence that the Registrant had reflected on, or understood, what caused her to assault Patient

A; and thirdly, the Committee was wrong to place reliance on: the Registrant's expressions of remorse; the annual refresher courses; and her cognitive behaviour therapy.

Ground (3): charge 6(b)

73. The PSA submits that the Committee was wrong to find that the Registrant did not breach the Interim Order by failing to disclose the conditions immediately to *the Trust.* The interim order required her to disclose the conditions to any organisation for whom she worked and not limited to the agency.

Ground (4): charges 5(a) and 6(a) were misconduct

74. This concerns the finding that the Registrant worked for Day Webster when under the Interim Order she was required to work only for two other agencies; and secondly the finding that she failed to disclose her conditions of practice *immediately* to *Day Webster*. The PSA submits that the Committee was wrong to find that these breaches did not amount to misconduct. A breach of an interim order is a serious matter whether it is dishonest or not. The Committee failed to address the inherent seriousness of a breach of interim conditions. Working for Day Webster in breach of the Interim Order was a deliberate breach. The Registrant must have known she was only permitted to work for two agencies. These breaches should have been considered by the Committee as part of an overall course of conduct which reflected an attitudinal failing and added to the overall seriousness of the case. They should be taken into account as additional reasons why suspension was not sufficient.

Ground (5): reasons

75. The PSA submits that the Committee failed to provide adequate reasons for its decisions that (1) the Registrant had sufficient insight; (2) there was no evidence of deep-seated personality or attitudinal issues; (3) the misconduct was remediable and not fundamentally incompatible with continued registration; (4) the public interest could be sufficiently marked by a suspension order; (5) that it was appropriate to depart from the relevant guidance.

Analysis

76. In my judgment the Committee made a number of errors both of principle and of evaluation in the Decision - both in its findings on sanction, and in its underlying findings of misconduct and impairment upon which the decision on sanction was based. Whilst the PSA has helpfully sought to identify distinct grounds of appeal arising from these errors, I consider the points raised in Grounds (1) to (4) compendiously. (In light of my conclusions, I do not address Ground (5) distinctly).

Public confidence

77. By way of general observation, in its consideration of impairment, whilst referring to the need for honesty and integrity, the Committee failed to mention the duty of a nurse to ensure that patients do not come to harm, whilst in their care. In what is a fundamentally caring profession, for a nurse deliberately to cause harm to a patient is antithetical to the pursuit of the profession. Public confidence in nurses relies not just

on honesty and integrity, but on their commitment to caring for, and not deliberately harming, vulnerable patients. The Committee's analysis of impairment and sanction omitted reference to this aspect of public confidence in the profession.

The findings of misconduct and impairment

78. First, as regards the assault, the Committee's description of the nature of the misconduct, as being a reaction in response to fast moving events, misrepresents the true position and understates its seriousness. It is clear from the CCTV that the assault was not a reaction in the heat of the moment. At the point of the assault, Patient A had been fully restrained by six male members of staff (other than the Registrant) and was lying prone on the ground. He presented no threat to the Registrant. The Registrant first deliberately took a chair from a colleague to use it against Patient A and secondly, after standing away for a time, walked around his body and went back to kick him for a second time. The Committee failed to take account of these facts. Moreover, the Committee erred in referring to, and relying upon the Registrant's "standing and experience" as a reason for characterising the assault as misconduct. It was irrelevant. Any nurse, however inexperienced, would have known how to control his/her reactions and to remain professional. Furthermore, this was not a case of merely placing Patient A "at risk of harm" (see paragraph 82 below). These assessments of the Committee were evaluative judgments, which, on the evidence, no reasonable tribunal could properly have reached.

79. Secondly, as regards the assault, the Committee's finding of no impairment on grounds of public protection is flawed for two reasons. First, the Committee's distinction between public protection, and other "grounds" of impairment is confused and wrong in principle. "Public protection" is *the* over-arching objective (see Article 3(4), section 29(4) and the Sanctions Guidance); the other "grounds" of public confidence and professional standards are sub-aspects of public protection (see Article 3(4A) and section 29(4A)). Secondly, and more significantly, the finding itself was based the Committee's finding of sufficient insight into the assault, "capable of remediation" and thus no risk of repetition. However this finding failed to take account of the following facts:

(1) The Registrant denied the primary facts of the assault throughout the Committee's proceedings (as well as previously) and maintained an account which flew in the face of the clear evidence provided by the CCTV (as she did at the hearing before this Court) and which sought to blame others: see *Sayer* §25(4) *Sawati* at §§ 109-110. No explanation for her actions was, or has ever been, provided by the Registrant. The Committee did not address the matters set out in FTP-13b (paragraph 34 above.)

(2) The training subsequently undertaken was training in restraining techniques, and was not directly "relevant" to what had happened. The assault was not a case of an over-physical restraint using the wrong techniques and which had gone wrong "in the heat of the moment". The guidance at FTP-13a (paragraph 33 above) suggests that violence or abuse of a patient may not be capable of being addressed by training courses.

(3) The Registrant's reflective statements maintained that it was an "alleged" assault and provided no insight into or reflections upon her action. She continued to characterise everything that had happened as being part of the "restraint" and made no reference to what she did once the Patient A was restrained. She described the patient's "restraining experience" as "not a nice one". Nor is there any evidence of insight on the part of the Registrant as to why an assault on a patient is antithetical to practice as a nurse and its impact upon public confidence in the profession as a whole.

(4) The Committee placed reliance upon the Registrant's cognitive behavioural therapy. However there is no evidence that this addressed insight into why she had assaulted Patient A.

80. Whilst this Court will be slow to interfere with a tribunal's findings on insight, in my judgment, these flaws in, and omissions from, the Committee's assessment and reasoning are so fundamental that no reasonable tribunal could have concluded that the Registrant has sufficient insight into the assault.

81. Turning to the dishonesty, it was repeated, at least to the extent that the Registrant on two occasions separated by three weeks, made false statements, each of a somewhat different nature. To this extent, the Committee's finding that the dishonesty was one-off is open to question. Moreover the dishonesty was not subsequently repeated because it was discovered by the Trust. The Committee found that the Registrant had shown insufficient insight into her dishonesty, that there was a risk of repetition and on this basis made a finding of impairment. Moreover, the dishonesty and the assault formed part of a single course of conduct, thereby aggravating the seriousness of both elements. In these circumstances, I consider that the Committee erred in its evaluation that the dishonesty was at the lower end of the spectrum.

The findings on sanction

Aggravating and Mitigating factors

82. Before turning to specific sanctions, the Committee addressed aggravating and mitigating features. The Committee understated one of the two aggravating features it relied upon, namely that the assault placed the Patient A at "risk of harm". This was a significant understatement. The Registrant's assault was not negligent or reckless; it was deliberate and intended to cause actual harm. It will necessarily have caused at least some actual harm – both physical and psychological.

83. Further the Committee overstated the relevant mitigating features. Of the 7 mitigating features which the Committee identified, two related to insight into the assault, which for the reasons set out above, I consider to have been misplaced. Then, as to dishonesty, even if broadly related, there were two separate aspects of dishonesty. Finally three of the features amounted effectively the same thing, namely previous "good character".

Suspension, "fundamentally incompatibility" and striking off

84. In my judgment, the Committee erred in principle in its application of the Sanctions Guidance concerning a suspension order and fundamental incompatibility with continued registration.

85. Having ruled out lesser sanctions, the Committee turned to consider a suspension order. When it did so it went straight to the checklist of factors in the Sanctions Guidance at SAN-3 indicating where a suspension order may be appropriate. Then, having identified three such factors as applicable to the Registrant, only then did it consider whether the misconduct was fundamentally incompatible with continued registration, and found that it was not incompatible, precisely because of the three "suspension" factors it had found. The Committee then went on to state that striking off would be disproportionate and unduly punitive. Finally, in preferring a suspension order over a striking off order, it placed reliance upon the Registrant's "unblemished record".

86. In my judgment, in adopting this approach, the Committee erred in principle. It failed to give any proper consideration to whether the Registrant's conduct was fundamentally incompatible with continued registration. Having ruled out lesser sanctions, when the Committee turned to consider a suspension order, it should have considered, first, whether this was a case of fundamental incompatibility. The Guidance provides, at the outset, that suspension may be appropriate "in cases where the misconduct isn't fundamentally incompatible". This suggests that prior to considering the checklist of factors *favouring* suspension, fundamental incompatibility should be considered first.

87. Secondly, in its approach, the Committee failed to consider sufficiently the impact of the Registrant's conduct on public confidence in the profession and failed to consider a significant part of the Guidance relevant to this issue. Whilst stating, at the outset of its consideration of sanction, in general terms that it had had careful regard to the Sanctions Guidance, the Committee failed to refer to, and there is no indication that it took account of, the highly material guidance (FTP-3a) relating to "Serious concerns which are more difficult to put right". This guidance to which the Committee's attention is expressly drawn in the Sanctions Guidance itself, when considering "striking off", is set out in paragraph 31 above. Of the serious concerns identified in that guidance, three are present in this case – deliberate harm, deliberately false employment history, and practising in breach of restrictions. Such concerns are very difficult to remediate, because of the impact of such conduct on public confidence. Yet, there is no evidence that the Committee gave any consideration to this guidance and the "authoritative steer" which it gives: see *Khetyar*, paragraph 23(7) above. In this regard, the Committee erred in principle and that error undermines its conclusion that the misconduct in this case was not fundamentally incompatible with continued practice.

88. Thirdly, the three factors which the Committee relied upon to support a suspension order (*and* as the reasons not to find fundamental incompatibility) were matters of personal mitigation. They do not concern the seriousness of the underlying conduct or its impact upon public confidence. To rely upon matters of personal mitigation in this way was contrary to the approach identified in *Bolton* (paragraph 23(1) above), where the essential issue remains maintaining public confidence in the professions and where matters of personal mitigation are of less weight. Moreover the Committee failed to take into account the Guidance at SAN-1 (paragraph 27 above) that in cases of fundamental incompatibility, panels should bear in mind there will be usually be only extremely limited circumstances where the concept of a "previously unblemished career" will be a relevant consideration.

89. Fourthly, in rejecting a striking off order, the Committee made further errors. It did not give clear reasons for its conclusion that striking off would be disproportionate: see SAN-1 and paragraph 23(7) above. Moreover its express reliance on the "overly punitive" effect on the Registrant of striking off again ran contrary to the proper approach identified in *Bolton*.

The Committee's reasons for favouring a suspension order

90. The Committee found that there was *no* evidence of harmful deep-seated personality or attitudinal problems. In the light of the foregoing, this is a finding which no reasonable Committee could properly have reached on the evidence before it. There was at least *some* such evidence - namely: the circumstances of the assault itself; the Registrant's response to the initial investigation; the subsequent dishonesty; her response to the clinical manager's discovery of the breach of the Interim Order; and her denial of the allegations before the Committee. Moreover the Committee's own findings in relation to the dishonesty (insufficient insight and risk of repetition) is at odds with this finding of "no evidence" of such problems. Despite this finding of insufficient insight, the Committee went on to rely on "potential for insight" as a reason not to impose a striking off order. In my judgment, the Committee erred in not placing greater reliance upon the then current absence of insight (despite the passage of time) as a factor indicating a more severe sanction, as opposed to relying upon possible future insight as a reason *not* to impose that sanction. Further, for the reasons given above, in so far as the Committee relied upon the Registrant's insight into the assault as a basis for favouring a suspension order, its findings on insight were flawed.

Two further errors

91. Finally the Committee made two further clear errors. First, in my judgment, its finding that charge 6(b) was not proved was wrong, as a matter of pure construction of paragraph 6(a) of the Interim Order. Even though she may have been directly "employed" by the agency Day Webster, she was "working for" the Trust. She was therefore required to, but did not give, a copy of the Interim Order to the Trust. Secondly, the Committee completely failed to consider whether charge 5(a), which the Registrant had admitted, amounted to misconduct. Charge 5(a) concerned working for Day Webster, rather than Trust Care or Pertemps in breach of *paragraph 1* of the Interim Order. In its consideration of misconduct in the Decision, the Committee wrongly confused this charge with the charges relating to paragraph 6 and notification of Day Webster and the Trust (i.e. charges 6(a) and 6(b)). But for these two errors, the Committee could, and in my judgment, should have gone on to find two further instances of misconduct. (As regards charges 6(a) and 8 and not notifying Day Webster immediately, I am not satisfied that the Committee's finding was wrong). Breach of conditions of practice is expressly identified in FTP-3a as another of the serious concerns which are more difficult to remediate. These two further findings of misconduct, not accounted for by the Committee, provide additional reasons why the sanction of suspension was not sufficient in this case.

Conclusion

92. In the light of the foregoing analysis, in concluding that a suspension order was the appropriate sanction and in finding that striking off order was disproportionate, the

Committee made errors of principle in its evaluation of the material and its decision fell outside the bounds of what it could properly and reasonably have decided in the present case. Taking account of the cumulative effect of these errors, the Decision was not sufficient for the protection of the public within section 29(4) of the 2002 Act. Accordingly, the Decision was wrong and will be quashed.

Remedy

93. I have considered whether, in these circumstances, the appropriate order is to remit the case to dispose of the case in accordance with the Court's directions. However, since the suspension order imposed by the Committee was for the maximum period of 12 months, in my judgment no purpose would be served by remitting the matter to the Committee. In my judgment, the only appropriate sanction is a striking-off order. Accordingly, the appropriate remedy is for this Court to substitute the sanction of striking-off.

Disposal

94. For all the foregoing reasons, this appeal is allowed. The Committee's sanction determination dated 17 January 2023 is quashed and I substitute for it an order directing the registrar to strike the Registrant off the register.

95. I shall hear the parties as to the form of the order, costs and any other consequential matters that may arise.