Neutral Citation Number: [2024] EWHC 2991 (Admin)

Case No: AC-2023-LON-003519

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26th November 2024

Before :

RICHARD KIMBLIN KC
Sitting as a Deputy Judge of the High Court

Between:

THE KING **(on the application of IBRAHIM)**	**Appellant**
- and -	
THE NURSING AND MIDWIFERY COUNCIL	**Respondent**

- -
- -

Aparna Rao (instructed by **RCN Solicitors**) for the **Appellant**
Robert Benzynie (instructed by **NMC**) for the **Respondent**

Hearing date: 14th November 2024
- -

Approved Judgment

The judgment was handed down remotely at 10:30 on 26th November 2024 by circulation to the parties or their representatives and by release to the National Archives.

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RICHARD KIMBLIN KC

Richard Kimblin KC sitting as a Deputy Judge of the High Court:

INTRODUCTION

1. The Appellant is a Registered Mental Health Nurse ("RMN") who has worked in this capacity since 2011. He appeals pursuant to Articles 29(9) and 38 of the Nursing and Midwifery Order 2001 against the Order of the Conduct and Competence Committee sitting as the Fitness to Practise Committee of the Nursing and Midwifery Council ("the Panel"), dated 31st October 2023.The Order was a 12-month Conditions of Practice Order with a review. It is suspended pending this appeal: Art 29(11) of the 2001 Order.

2. The Panel was dealing with events of the evening of 27 November 2017 and the morning of 28 November 2017 in respect of which he faced the following charges in relation to a night shift he undertook at University College London Hospitals NHS Foundation Trust.

   "That you a registered nurse:

   1) On 27 November 2017 to 28 November 2017 on one or more occasions prevented Patient A from leaving her room.

   2) Your actions at charge 1 were:
      a. Not supported by Patient A's care plan;
      b. Contrary to the advice of:
         i. Colleague A;
         ii. Colleague B.
      c. Unnecessarily caused distress to Patient A;
      d. Continued despite you being aware of Patient A's distress.

   3) In response to being questioned by colleagues relating to your actions in respect of Patient A:
      a. Raised your voice to Colleague A;
      b. Raised your voice to Colleague C.

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

3. Charges 2(a) and 2(b)(ii) were dismissed at half time pursuant to the NMC Fitness to Practise Rules 2004, rule 24(7):

   a. The Panel found that there was no care plan in place (charge 2(a)).

   b. Colleague B was the nurse in charge during the shift. His whereabouts were unknown and he was not cooperating. His evidence was admitted as hearsay (opposed) but the Panel then dismissed charge 2(b)(ii) at half time.

4. The Panel found the remaining charges proved. They then decided that those facts amounted to misconduct and found that the Appellant was impaired. Separate to the substantive order, an 18-month Interim Conditions of Practice Order (ICOPO) was also made. This had immediate effect. This order was intended to ensure that the Appellant

(whom the Fitness to Practise Committee had determined was not fit to practise and whose practice needed to be subject of conditions, if it was to be safe) was not able to practise without conditions, and thereby put patients at risk, whilst the period for appealing ran and, in the event, whilst his appeal was awaiting final disposal. The reality, therefore, is that despite suspension of the Order, the Appellant was in any event subject to conditions of practice by reason of the ICOPO.

5. This case is about the Appellant's case, the situation he found himself in and whether or not the Panel grappled with that case and the context of the events which were the subject of complaint. It is therefore necessary to set out the material which the Appellant was relying upon as justification for what was alleged, then to look at how the Panel approached the Appellant's case.

BACKGROUND

6. The Panel set out the background in this way:

"You had 1:1 care of Patient A. Patient A had CNS lymphoma, suffered from paranoid schizophrenia and was on a palliative care pathway. The NMC witnesses described her as five foot four inches, frail to the point of malnourishment and moved with a shuffling gait. When she became agitated, because she could not articulate her concerns, the ward practice was to allow her to walk at her liberty around the ward which de-escalated her behaviour. The NMC witnesses stated that her behaviour on that evening was no different from her usual behaviour and she was not an aggressive person. On the day shift of 27 November 2017, this was the first shift that Patient A was subject to 1:1 care, prior to that she was always subject to 2:1 care with an RMN and an Health Care Assistant (HCA) caring for her. The NMC witnesses stated that they had informed you of the ward practice in allowing her to walk around the ward unrestricted.

In the early hours of 28 November 2017, Colleague A saw that you had closed Patient A in her room and you were holding the door closed. Patient A was plainly distressed, knocking on the door to be let out. Colleague A claimed that she told you 'you can't do that' and that Patient A should be allowed to pace around the corridors. You apparently stopped holding the door closed at that point. When she returned from her break Colleague A claimed that she saw that you had shut Patient A back in her room and she could see and hear that Patient A was distressed. Colleague A claimed that she told you that Patient A should not be locked in her room. Your response apparently was that this is how you worked as a mental health nurse. In the morning, Colleague A made a complaint to Colleague C about your behaviour and included a note in the patient's notes. It is alleged that you raised your voice to both Colleague A and Colleague C when you were confronted with this.

Your case was that this patient was five foot eleven and not frail but slim. She was a falls risk due to the way she walked and the fact that she spilt liquids whilst walking on the ward. At times she would inadvertently walk into other patient's bays and distressed them. She was extremely difficult to deal with alone. She should have received 2:1 care still. At one point whilst you were caring for her, she ran towards the exit. At other points while she paced the corridors she was spilling milk down herself and on the floor as she had difficulty swallowing. When she was taken back to her room, she threw a pot of yoghurt towards you and you feared she was going to attack you. It was your opinion as a RMN, that the best treatment was to restrain her in her room by holding

the door closed. You claimed that this was appropriate in all the circumstances."

7. The Panel gave short reasons on misconduct. It had regard to the *Code of Professional Standards of Practice and Behaviours for Nurses and Midwives* ('the Code') and found that the Appellant's actions fell significantly short of the standards expected of a registered nurse and amounted to a breach of the Code. In the following two paragraphs, the Panel found misconduct:

   "The panel considered that based on the evidence put before it you did hold Patient A's door shut on more than one occasion. You did not listen to the advice of Colleague A who informed you during the oral handover how they normally care for Patient A. The panel determined that you did go against the advised practice for Patient A. The panel further determined that Patient A was very unhappy with your standard of care. Patient A was physically showing signs of distress and you did not respond to this behaviour. The panel was of the view that this compounds your conduct and therefore determined that your actions were serious.

   The panel considered that you approached Colleague A and in your own evidence you stated that you did raise your voice to get your point across. The panel determined that you were defending your position when you knew you had done something wrong. The panel considered that your actions fell below the standards expected of a registered nurse and amounted to misconduct, albeit not serious misconduct as per the test set out in Roylance."

8. The Panel commenced its reasons on impairment with this incontestable statement of the role of the profession:

   "Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. 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."

9. The Panel determined that these fundamental tenets of the profession had been breached. Patient A was put at risk and was caused emotional harm as a result of the Appellant's misconduct.

10. Further, *"the panel was of the view that you have failed to demonstrate any remorse or reflected on your actions. The panel determined that you have shown limited insight and have failed to recognise the effect your actions had on colleagues or the nursing profession, or listening to staff on a ward that you were newly coming into."* The Panel found that the Appellant's fitness to practise was impaired.

11. Those are serious findings on matters of the utmost seriousness. The Panel made *"a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order"*

12. The Appellant advances two grounds of appeal.

Ground 1: that the Panel's conclusions at the Factual and Misconduct Stages failed to mention or engage with his submissions on the facts.

Ground 2: that at the Impairment Stage the Panel placed too great an emphasis on, and drew impermissible inferences from, what they wrongly considered to be a lack of insight.

LAW

13. No issue of law arises in this case. The Respondent helpfully referred me to well known cases on reasons in appeal cases. Where a tribunal's reasons are not clear, the court should look at the underlying materials to seek to understand its reasoning and to identify reasons which cogently justify the decision. An appeal should not be allowed on grounds of inadequacy of reasons unless, even with the benefit of knowledge of the evidence and submissions made below, it is not possible for the appeal court to understand why the tribunal reach the decision it did: *English v Emery Reimbold & Strick* [2002] 1 WLR 2409 at [89]. The standard should not be set too high and not every point has to be recorded: *General Medical Council v Awan* [2020] EWHC 1553 (Admin) per Mostyn J at [12]. Giving reasons is not a slavish exercise, but the parties do need to be able to understand why they have won or lost: *Re F* (Children) [2016] EWCA 546.

14. When considering misconduct, appropriate respect should be given to the specialist assessment made by the Panel, but no more than warranted by the circumstances: *Ghosh v GMC* [2001] 1 WLR 1915.

15. Insight is concerned with risk of repetition. Problems may arise from denial of misconduct when assessing insight and admission of misconduct is not a precondition of being able to show insight and low risk of repetition: *Sawati v GMC* [2022] EWHC 283 (Admin) 94 at [94]-[97].

THE HEARING AND DECISION-MAKING

16. The Panel sat between Monday 5 June 2023 and 14 June 2023 and then on 30-31 October 2023. The Panel comprised three members, two of whom were lay members and one of whom was a Registered Nurse. The Panel was assisted by Legal Assessors. The NMC was represented by a Case Presenter. The Appellant was represented by Ms Rao of Counsel. It gave findings and reasons in writing in a report comprising 48 pages.

17. The structure of the proceedings and reasoning is as follows:

    a. Hearing the evidence of the principal witnesses for the parties either in person or virtually. Witnesses were cross-examined.

    b. So far as evidential and procedural issues arose, the Panel ruled on those and gave its reasons in writing.

    c. The function of that evidence was to determine the facts, so far as they were in dispute.

    d. Submissions were made in writing and orally on the facts.

e. The Panel considered the evidence, made and recorded its factual findings including as to whether there was a case to answer.

f. This process resulted in findings on whether the charges were proved, or not, on the balance of probabilities, with the burden on the NMC.

g. Having found certain charges proved, i.e. having determined the facts of the case, the Panel decided whether the Appellant's fitness to practise was impaired. At that stage, there was no burden or standard. It exercised its professional judgement in two stages.

h. The first such stage was to decide whether the facts found proved amounted to misconduct.

i. The second such stage, and only if the facts found proved amounted to misconduct, the Panel decided whether the Appellant's fitness to practice was impaired as a result of that misconduct.

j. The Panel considered sanction.

18. The charges as drafted are therefore a stepping stone in the decision-making. They are simple statements of the factual matter which is alleged to be professional misconduct and thus to justify a finding of impairment.

19. En route, the Appellant put his case. His case on the facts differed to some degree from that of the NMC. He also advanced a case which brought in the context in which the alleged facts and misconduct occurred. He relied on that context to explain and justify what had happened. That part of the Appellant's case was especially relevant to the points at (h) and (i) above: misconduct and impairment.

THE CONTEXT

20. There are four sources of contemporary or near-contemporary material which provide the background to the allegations. First, there is the Deprivation of Liberty Order for Patient A. Second, there is what was alleged by the Respondent to be Patient A's care plan. Third, there are practitioner notes from 27th/28th November 2017. Fourth, the Appellant made a statement on 13th December 2017 in which he gave an account of the night in question.

21. The Deprivation of Liberty Order ('DOLS') in force at the relevant time was dated 24th November 2017. It is one of a series of such orders. It is a nine-page document which is bespoke and detailed in respect of Patient A's capacity and interests. It was prepared in consultation with the nurse in charge of the ward and a Mental Health Assessor, who was a doctor. It is made under Part 8 of Schedule A1 to the Mental Capacity Act 2005. The 2005 Act provides a scheme which applies where the managing authority of the relevant hospital or care home are to provide care for a patient who lacks capacity.

22. The DOLS records that Patient A had a diagnosis of paranoid schizophrenia, a history of substance abuse and a long history of mental illness and non-compliance with medication. She was detained under the Mental Health Act 1983 in March 2016. After surgery, Patient A became noticeably confused. She required chemotherapy, which was

the reason for her transfer to University College London Hospital. Patient A had substantial care needs, was reportedly challenging and aggressive and was commenced under two-to-one care to reduce risks related to her behaviour.

23. The nurse in charge pointed out that Patient A could not recognise the severity of her condition or the risks related to her cognitive impairment which included falls and misadventure. Patient A was now more compliant than when she was admitted to the National Hospital for Neurology and Neurosurgery where she had forcefully left the ward, but the decision had been made to continue two-to-one supervision to ensure her safety and wellbeing.

24. On assessment by a consultant psychiatrist, the current care plan was agreed, including restrictions on Patient A's liberty. The restriction on liberty was to be kept in the hospital for the purpose the relevant care or treatment. She was not permitted to leave the ward without the permission and assistance of staff.

25. There is a single-page document which was alleged to be a care plan. The Panel found, essentially, that it was not a care plan and therefore the Appellant had not failed to follow it. Accordingly, the Panel dismissed charge 2a at half time.

26. The document which was alleged to be a care plan states:

"Patient A is a RISK OF ABSCONDING and has absconded twice whilst under 2:1 supervision.

Patient A has expressed suicidal intentions previously so ensure you are watching her at all times.

Patient A is a huge falls risk- please keep your hazard perceptions about you and move any objects that Patient A could fall over out of the way.

…

Don't close the door and not be able to see her, your role whilst on the ward is to supervise Patient A.

…

She likes to walk- please walk with her ensuring her surroundings are safe.

If she would like to go outside <u>please ensure two people accompany her and keep eyes on her at all times.</u>"

27. The relevant pages of Patient A's history notes state as follows, on my reading of the manuscript:

"University College London Hospitals - In-Patient History Sheet
27.11.17 NURSING – LONG DAY
19:00 (S) Patient very agitated throughout the day.
…..

[Signature] Staff Nurse

28.11.17 RMN [Appellant] ENTRY: PROGRESS NOTES
06:50 [Patient A] presents as restless and unstable in mental state. She did not through the night. She kept pacing round the ward and sometimes was observed running towards the exit. She was given PRN to help her settle but with no effect. RMN [signature]
28.11.17
07:45 [Patient A] was +++ agitated, distressed and upset overnight.
(O) not for obs + bloods, behaviour change overnight, perhaps down to reduction of 2:1 → 1:1.
(A) Mobile around the ward all night (??) until RMN made decision to not let her out of her room. [Patient A] was very close to falling several times throughout the night, RMN stated it was best to stop giving her Haloperidol as it would make her unsteady and pace more. Explained to RMN that this wasn't how [Patient A] was previously treated and it wouldn't work for her. Explained she normally paces and drank ??? and yoghurts. …… Suggested to RMN it was best to not keep her in her room as her behaviour was getting increasingly worse. [Patient A] was crying and knocking on the door, eventually retired to sleep for approx. 15 mins, woke up again and continued to knock on the door and remained agitated. On entrance to [Patient A]'s room she was laying on the floor, managed to get her up and to bed. [Patient A] continued to pace this AM once out of the room, she does remain unsteady. Conversations were had with RMN several times throughout shift re: not keeping [Patient A] in the room not only by myself but by other nursers. Sat with [Patient A] towards end of shift to comfort – responded well for short amount of time.
[signature – [X], Staff Nurse]

28. The notes provide both a record of Patient A's behaviour and views about how to deal with it. Similarly, the Appellant's statement of 13th December 2017 provides his account of the circumstances and events to which I have added emphasis:

"10. When I took over her care, my first initial assessment was that the patient presented as restless, confused and unstable in mental state. Communications with her was very difficult as she had incoherent speech and was preoccupied with auditory hallucinations (talking to herself). She was also wet, pacing round, kept going into the kitchen and kept drinking milk and water. In fact, she had yoghurt, water and milk in her room. Her being wet was due to the fact that most of the fluid she was attempting to drink was actually being emptied on her cloths. She was drinking voraciously. From my experience, her presentation suggested she needed to be placed on 2:1 level of observation. I asked the staff nurse in charge of her care (the complainant) the reason the patient was not nurse on 2:1 level of observation since her presentation clearly indicates she meets the criteria. Her reply was that the patient had recently been downgraded from 2:1 level of observation.

12. She continues to pace round and frequently went to other bays, invading other

patient's personal space and disturbing their care. Occasionally, she will deliberately put herself on the floor in the corridor and It will often take several minutes, persuading her to get up. She also sometimes pushes me. Even though she was severely disturbed, she had no management plan on her folder. I asked the nurse for her mental health care plan and she said she is not aware of the existence of any. It was clear from her presentation that she had no capacity.

13. At about 21:50, the patient was given an injection, I think it was haloperidol and some benzodiazepine to help her relax. But she continued to pace round, going to other patients' beds and into the kitchen.

….

15. At about 01:30, the female staff nurse with the help of another nurse gave the patient another injection of haloperidol. I suggested to them benzothiazine would have been more appropriate since she was very agitated; displaying aggressive behavior and needed medication to help quickly calm her down.

16. At about 01:50 she became increasingly difficult to manage. She also appears to be in pain. I asked her whether she was in pain and she confirmed being in pain. I told the female staff nurse and some minutes later the patient was given another injection.

17. At about 02:20 her behavior deteriorated. She became risky to herself and others. She was frequently going to other bays, disturbing other patients, going into the kitchen and forcing her way inside the clinical room. She attempted to leave the ward on few occasions through the exit. At some point during this time, she went inside the kitchen and took a 1-liter bottle of milk from the fridge. It was at least half full. She began to drink directly from the bottle whilst pacing round. The milk was not only pouring on her cloths, but it was also dripping on the floor as she walks along. She was also drowsy and struggling to walk. She slipped on two occasions. At this point it was clear she was at risk of falling and immediate action was needed to remove those risks. I had a quick discussion with the male staff nurse (the nurse in charge) during which I drew his attention to the increased risk of her falling; the need to ensure her safety and other patients safety. As there was no management plan for her, I invited his suggestions as to how best we can manage the risk. He said to me I am the RMN and that I should use my mental health nursing skills. My reply was that, if it was a mental health ward, the most appropriate place to manage her would be in her room. I requested they call a doctor to see the patient, but this did not happen, at least whilst I was on the ward. The complainant, except giving the patient her medication, played very little role in her care. Her contact with the patient was mostly when the patient tries to force herself inside the clinical room or giving her the injections.

18. At about 02:45, the patient was in the corridor and suddenly started to run towards the exit. I followed her to the exit and I observed her examining the door and it was clear she was determining to leave the ward. On her way to the exit she was still carrying the bottle of milk she took from the fridge. She slipped on the floor on her way to the exit. Consequently, I assessed and concluded there was a real possibility of harm if no action was taken. I took the decision to walk her to her room. I used a friendly come along technique in walking her to her room. This is a least restrictive and pain free techniques used in holding a patient hand and guiding her where to go. Walking

her to her room was not more than 2 minutes. She did not resist but simply walked along, following my guide.

19. Whilst in her room, I took her to her bed and encourage her to stay in bed, using verbal de-escalation techniques. Initially, it worked. She stayed in bed for about 10 minutes, got up and moved and sat on a sofa. I sat on a chair near the door but inside the room. I noticed her cloths was wet and I asked [X] to help change her. Her room had a supply of water, yogurt and she was still keeping the bottle of milk she took from the fridge. I reminded the staff nurse the need to call a doctor to see her because she was severely disturbed, but no doctor came. She laid on the sofa briefly and got up and started to eat yogurt. At some point whilst eating the yogurt, she yelled as she threw the yogurt at me. She started to come towards me and that was when I pulled out the chair out of the room and closed the door. I genuinely held a belief that she was going to attack me. This was about 03:20. The door was not locked: I had no keys to the door. It was merely that I closed the door to prevent her from physically attacking me. I believe my action was proportionate to the risk of harm and its seriousness I perceived, and it was the least restrictive thing I could do for her safety, my own safety and the safety of others.

20. I stood by the door and continued to monitor her from the other side. I also continued to use verbal de-escalation techniques to persuade her to return to her bed or the sofa. But within two minutes, she decided to put herself down on the floor and refused to get up.

21. At about 03:40 a senior nurse, I suspect she was the unit coordinator, visited the ward and came to see how the patient was being managed. I explained to her the various events and the fact that she placed herself on the floor and refused to get up despite my attempts to persuade her. She also tried but was unsuccessfully in persuading her to get up. Again, I ask the complainant to call a doctor to see her, but no doctor came. I also requested for my break, but I was told there was no one to relieve me."

29. The Panel did not hear from Patient A, who did not have capacity to make a statement, and had passed away (for reasons unconnected to the allegations) by the time of the hearing 5 years later.

30. The Panel heard evidence from Colleague A, a Registered Nurse who had been on the night shift, and Colleague C, the ward sister who arrived the following morning. They also heard evidence from the Appellant and from Witness 1, the RMN on duty on the day shift on 27 November 2017.

31. In respect of charge 1, the Registrant accepted that he prevented Patient A from leaving her room for 1-2 minutes somewhere between 2:45am and 4am. He did so because Patient A had thrown a yoghurt at him and was moving towards him in anger.

SUBMISSIONS MADE TO THE PANEL

32. Written and oral submissions were made to the Panel on the Appellant's behalf. For example, the Registrant's written submissions set out:

"The Hospital's failure properly to create, implement, and maintain the Patient's care

plan

"8. The precipitating factors for the events of 27-28 November were the failure to create, implement, or maintain an adequate care plan, followed by the improper and unjustified decision to downgrade Patient A's care from 2:1 to 1:1.

"9. This colours the entirety of the problem faced by those on the night shift.

"10. The Panel has read the patient's notes and DOLS assessment. It cannot be disputed that the patient had a history of aggression, absconding, hallucinations, refusal to cooperate with staff, being a serious falls risk, and complete inability to safeguard herself from harm. The NMC's witnesses universally fail to acknowledge the patient's true condition in their statements (two even going so far as to assert that the patient was not aggressive, C §§3, 8, A §§6. B said the patient was not at risk of absconding, §4). That makes their opinion as to what was professionally appropriate on that night of limited value to the Panel.

"11. In contrast, the Panel has heard evidence from Mr Ibrahim and Witness 1 (both RMNs) to the effect that on 27th November, the patient posed a real and significant risk of falling, and was actively interfering with the well-being of other patients. Additionally, Mr Ibrahim reported that the patient tried to exit the ward. The NMC attempted to suggest, at length, that he has invented this because he did not enter it into the activity chart. This imputation goes nowhere, because Mr Ibrahim recorded it in the clinical notes and it is consistent with the multiple mentions of absconding in the DOLS notes that Mr Ibrahim had not seen when he made his entry.

"12. It is also plain that the patient did have access to illicit drugs whilst on the ward. Different nurses have recorded this suspicion in the notes. It affected her behaviour and introduced an unknown quantity into the way she needed to be cared for. It highlights the need for decisions on downgrading care to be made and documented by the appropriate qualified clinical team, and not by a single individual on an ad hoc basis.

"13. The way in which Colleague C made her decision is extremely worrying. She had already sought to have care downgraded before the DOLS assessment had been made. The reason she gave for this (that 2 staff speak to each other and get distracted) flies in the face of the overwhelming clinical justification for 2:1 care (or higher) in psychiatric wards around the country and again shows why the decision has to be made by the clinical team after due consideration and with reference to the DOLS assessment. Fortunately, the Mental Health doctor specifically rejected her suggestion.

"14. The DOLS assessment made 2:1 care a condition of the patient's care. The Managing Authority (UCLH) was to consider lessening the care to 1:1 "if Patient A becomes more settled". Colleague C did not hold the power to do this. Her decision was not documented or clinically justified by reference to the DOLS assessment or the observations of Dr [S]. There can be no doubt that it should not have been taken or implemented on 27 November.

"15. The Panel will note – and may be concerned by – the lack of any clinical decision, risk assessment, or record of the decision to downgrade care."

33. The written submissions then set out his explanation why the incident occurred.

"The reasons for the incident occurring

"16. The simple truth is that, had Colleague C complied with the DOLS assessment condition of 2:1 care instead of unilaterally changing it on the morning of 27 November, the Registrant would not have been in a position where he had to manage an unstable and potentially dangerous patient alone.

"17. It is highly significant that Colleague A and Colleague B did not know how a RMN should deal with this patient on a 1:1 basis. They had never even been part of the 2:1 teams that looked after the patient before the 27th. Colleague A had been the general nurse on duty but had not been allocated solely to Patient A. They do not appear to have been consulted or even briefed on Colleague C's decision to reduce care.

"18. It is perhaps understandable that Colleague A found the Registrant's behaviour frustrating and difficult to empathise with, because she had been used to seeing the Patient cared for by 2 people. The way that she had expected RMNs to deal with Patient A was hugely dependent upon there being an additional person on 2:1 duties. On this night, she was faced with a new situation. Acknowledging that the patient needed 2:1 would have meant (a) undermining the authority of the permanent Ward Sister who had considerable power over her working life, (b) finding additional staff for a notoriously difficult patient, and (c) jeopardising the care of their other patients.

"19. Colleague A did attempt to note the possibility that the care reduction caused the patient's changed behaviour. Colleague C did not agree, and it is notable that her statement makes no mention of the change caused by care reduction. She instead states (§3) that "the change of environment made the patient quite distressed, so we de-escalated her to a singular RMN". At best, this is a selective and inaccurate picture of that fateful decision.

"20. After making that clinical note, Colleague A appears to have forgotten all about the change caused by the care reduction. Her statement is silent on it, and in oral evidence she had zero recollection of whether the patient was on any kind of special care.

"21. Having received all of this information, it is unfortunate that the NMC chose to blame the Registrant for the problem instead of acknowledging its true origin: the fundamental unworkability of Colleague C's sudden de-escalation of care.

"22. This blame-allocation can be seen in the extreme nature of the language used by Colleague A. She accused the Registrant of "locking" the patient in her room (§§9, 12). This is an unjustifiable, prejudicial exaggeration and borders on simply being untrue. Her unfounded assertion of laptop-use is unbelievable and only exists to prejudice the reader against Mr Ibrahim. Her words, "it seemed as though Ishaq made rules to suit himself" (§8) suggest a personal dislike that is unjustified on an objective assessment of her interaction with the Registrant.

"23. Colleague C's evidence was similarly defensive and defective. At no point in her statement or her evidence did she show any insight into the problem that she had personally created by acting beyond her authorised powers. She blithely asserts, in the face of the extensive DOLS assessment, that the patient was not aggressive, not a danger to anyone, and that "as long as she had supervision she was fine" (§3). She

then goes on to criticise the Registrant for failing to provide that supervision, when she is the person solely responsible for having suddenly and fundamentally changed the nature of that supervision. She failed to log a Datix report until February of the following year, thereby making it impossible for any of her clinical superiors to examine the circumstances of this incident in a timely fashion.

"24. The problem that occurred on this night would have been entirely avoided had Colleague C not seen fit to ignore the extensive DOLS process and the requirement that only the hospital, through its clinical team, exercised the authority to make a properly informed and documented medical decision to downgrade care requirements.

"25. It is perhaps significant that Colleague B, the one witness who is less judgmental of the Registrant and seems to have at least a passing respect for the professional experience of a RMN, has not given live evidence to the Panel."

34. Having set out the material on which the Appellant relied before the Panel, I turn to Ground 1, which relies upon the omission of that material.

A FAILURE TO CONSIDER THE APPELLANT'S CASE AT FACTUAL AND MISCONDUCT STAGES?

35. Ms Rao submits that the Panel's reasons in finding that the remaining charges were proved failed to deal with the Appellant's arguments. Those arguments are concerned with the lack of an adequate care plan and sufficient staff. They justify his actions. In particular, Ms Rao submitted that the Panel did not engage with the Appellant's factual submissions that:

    a. The patient was a proven physical risk to herself and others and was at risk of absconding;

    b. The patient was subject to a Deprivation of Liberty Safeguards ("DOLS") assessment that permitted deprivation of liberty under the Mental Capacity Act 2005;

    c. The DOLS order required 2:1 care as a condition of that order;

    d. Shortly before the Registrant's shift, Colleague C unilaterally downgraded Patient A's care to 1:1 without adherence to the proper procedures;

    e. The patient had no care plan;

    f. The Registrant was informed of (a) and (b), but not of (c), (d), or (e) when he came on shift;

    g. The Registrant was therefore in a position where he could not leave the patient in order to remedy any of the above matters, had little support from other overworked staff. He prioritised the safety of his patient and of those around her.

36. Mr Benzynie submitted that the Panel should have and correctly did focus on the shutting of the door to Patient A's room. In my judgment, this is the only submission in support of the Panel which Mr Benzynie could make. He was constrained to do so in

the absence of adequate reasons within the Panel's report to explain why the Appellant's case was not accepted. I do not accept Mr Benzynie's submission.

37. In my judgment the context of the complaints against the Appellant are germane, and are capable of explaining and justifying the factual matters which were established against the Appellant.

38. It is not disputed that Patient A was of such a risk to herself and to others that it was necessary to deprive her of her liberty by use of 2:1 care. I have set out in detail the evidence which was available as to both the root cause of those risks and the ways in which they did and could manifest themselves. They may be properly characterised as substantial challenges and risks which were unpredictable and capable of developing very quickly.

39. It is also of obvious significance that the Appellant was placed in the sole care of Patient A, contrary to the level of provision which had been signed off by an experienced and expert body of medical professionals in the DOLS. In my judgment, this is a circumstance of such clear materiality that it had to be fully grappled with in the Panel's decision. The DOLS is a carefully considered and reasoned document which has a statutory basis. While this case is not directly concerned with a departure from the DOLS in that the charges do not allege that any party was in error for allowing circumstances to exist in which the care provision was reduced from 2:1 to 1:1, it is an authoritative statement which plainly should have been followed unless and until it was varied. The Appellant was correct to rely on it.

40. Still further, it is relevant that the Appellant was new to the ward and had no care plan from which to work. These matters show that the Appellant was put into a challenging situation with arguable systemic failings which were not of his making.

41. Arguments arising from the above were clearly and cogently articulated on the Appellant's behalf via written submissions, as I have set out, and were supplemented orally. Given that the Appellant recorded absconding behaviour in the clinical notes and that is consistent with the similar absconding behaviour referred to the DOLS notes, which the Appellant had not seen when he made his entry, the Panel had to engage with the reality of what the Appellant faced and the extent to which that was a situation which, arguably, he should not have had to face, alone.

42. It is a matter of fact that the Panel did not mention these arguments in their findings section. The Panel had to grapple with them. The Appellant is entitled to know why such important arguments, on which his defence rested, were apparently rejected.

43. In order to find the NMC's allegations proved, the Panel was required to decide whether the Appellant had clinical justification for keeping the patient shut in her room. I find that it is not possible to see how the Panel could have made a fair and rational decision while omitting to address the terms of the DOLS order, the inadequacy of staffing, and the patient's history of dangerous and aggressive behaviour.

44. In a case in which the registrant's case is justification of the action or omission which is alleged, the Panel must at some stage make findings about that the justification which is relied upon. In this case, it was necessary to make both findings of fact and also findings about the appropriate range of responses to the circumstances. The Panel had

to go further than making findings on the factual matters which were set out in the charges. It was necessary to go on to set out what the Panel found the situation to be. How was Patient A behaving; what were the risks to her, to other patients and to staff including the Appellant; what is the significance of the difference between the DOLS and the care actually provided? This is not an exhaustive list nor a checklist. Rather, they are examples of the issues which are plainly important but have no related factual findings nor assessment.

45. These findings could have been made either as factual findings or in considering misconduct, namely stages 'f' and 'g' as set out at paragraph 17 above, or some sensible division between the two. In any event, the Panel had to reach conclusions about the overall circumstances which the Appellant said justified his actions. It is clear from the DOLS, the absence of a care plan, the fact that the care ratio was halved that the Appellant's case had to be accepted to some extent, and I do accept that he was put in very challenging position. Absent that material, the Panel is left to consider only a part of the picture. The Panel's picture is in black and white and one-dimensional, whereas a fair picture needed colour and perspective.

46. The Panel evidently devoted considerable time and procedural care to its task. I note and have taken account of the careful reasons which it gave for its procedural decisions and as to the admissibility of evidence. The Appellant was correct to mount no challenge to the findings of fact which were made and explained. Those parts of the Panel's reasons stand in contrast to the absence of findings and reasoning on the core issues on which the Appellant's case depended.

47. Accordingly, Ground 1 is made out and the appeal is allowed on that basis. That suffices to quash the factual decisions and the finding of misconduct. The finding of impairment necessarily falls away. However, I should address Ground 2 albeit briefly.

DID THE PANEL ERR IN FINDING IMPAIRMENT?

48. The Panel had to make an assessment of the Appellant's fitness to practise at the date of the finding of the misconduct. The purpose of that assessment was to determine whether or not there was impairment of the Appellant's fitness to practise. An element of that assessment was the insight which the Appellant showed. In carrying out that assessment, it was important for the Panel to ensure that it did not equate lack of insight directly to impairment. By that I mean that it was not open to the Panel to conclude that the Appellant was not fit to practise because the Appellant disputed that his fitness to practice was impaired: *Sawati v GMC* [2022] EWHC 283 (Admin).

49. After receiving the finding of misconduct, the Appellant presented a Reflective Piece to the Panel, in which he stated:

"Throughout the period of time following my referral to the NMC until the finding of misconduct yesterday, I have had a great deal of time to reflect on what went wrong, my career development needs and what the future holds for me as a Mental Health Nurse. Here, I reflect on my fitness to Practise, insight and remediation, self-growth and continuous learning. I will try to demonstrate the steps I have taken to overcome any weaknesses in my practice or in my professional approach generally.

The Panel is aware of my account from December 2017. I would like to emphasise that

I wrote this account (pages 14-27) without seeing any patient notes, witness statements, or DOLS report. …

I recognise that caring for patient A proved very difficult and extremely challenging. I had never taken care of this patient before, so there was no existing therapeutic relationship and communicating with her was difficult due to her physical health and mental state. When the situation was getting out of control, I made certain decisions and action to manage the risk which later led me to become the subject of fitness to practice panel hearing …

Colleague A doubted my abilities and believe that I had made mistakes in taking care of the patient that night. Whilst I know I did my best with the patient, I can see that Colleague A was worried and I realise now that I did not deal with that as well as I should have.

Although I admitted I held the door once to prevent patient A from coming out, my denial of the other allegation of wrongdoing was maintained throughout the hearing and to this day. My reasoning behind this was that at all time I felt was acting in the best interest of patient A and so could not admit to something I did not do. It is understandable that the panel may conclude that because I denied some of the allegations and had to go through NMC hearing which has now found them proved shows my lack of insight to the regulatory concerns raised. I have personally been through the hearing process from day one and have had the benefit of listening to the panel members, the legal assessor and the NMC case presenter and my own counsel. I have also had the benefit of studying the NMC's Remediation and Insight Guidance which I was not aware of before.

This document is one of the hardest things I have ever written.

I am not a dangerous person or someone who intentionally or negligently violates the rights of other people. … I have also shown through testimonials, and through the hearing process whereby the NMC confirmed my good character. However, I understand why the NMC state that this action was misconduct and that this is a different dynamic to my own character. I am not an abuser who will pose a danger to patients and the general public. This case has now changed and taught me a very valuable lesson.

"Accurate documentation is the backbone of our nursing practice. I educate all those under my supervision to ensure that any documentation is accurate, factual and legible. Therefore, I am ashamed of myself that I did not apply the same practice.

"If I am faced with similar situation today I am 100% sure the regulatory concerns raised by the NMC will not arise. I am now well aware of my limitations and where there is a need to consult, raised a concern or asked for help in safeguarding my patient wellbeing I will not hesitate to do so. Since the incident was raised with me by my employer and the NMC and whilst I am allowed to continue working for the five and half years prior to my Fitness to Practise Committee hearing I have not had any allegation of misconduct in my areas of practice. I also always made sure the mental health nursing needs of my patients come first.

I deeply regret how lapses in this shift has caused such issues. However, as with every

period of challenge in my career, this has taught me a great deal also. I believe in learning from everything that happens, nursing is an amazing career for showing you that you never stop learning and highlighted to me the privilege of having such a stimulating profession. Although I have other career options, nursing gives me job satisfaction. …

I have thoroughly read the NMC Code of Professional Standards of practice and behaviours for nurses and midwives (NMC, 2015) and have reflected on the following in relation to this incident: …

Practice effectively: by not pushing much harder to get a doctor to attend when I realised the patient was really presenting a serious challenging behaviour mean I was potentially unable to practice effectively. This meant that I did not make sure that the patient immediate need to be seen by a doctor to prescribe appropriate care were not prioritised.

Practice effectively: by not conducting comprehensive risk assessment and making at least a basic written care plan that night of how the patient were to be nurse and get a senior nurse to agree to its implementation means that I did not practice effectively. I did take immediate and appropriate action as soon as I became aware that there was no care plan. I did not also comply with this as I did not complete all documents fully. The documents weren't complete, although at the time I was prevented from completing the notes, I should gone to the site manager, to lodge a complaint before going home.

Preserve safety: throughout the shift, I was preoccupied with the thoughts of making sure that patient does not fall. I think I have succeeding to some extent in ensuring her safety. Nevertheless, I did prevent her from leaving her room.

Promote professionalism and trust: In the light of the fact that this allegations have been found proved, I can understand how colleagues were feeling when they formed the opinion that I was failing the patient. I understand how the panel of the hearing felt I failed the patient. I have already taken measures to remedy the concerns raised. I have completing mandatory and required training, including safeguarding of children and adults and effective communication.

To improve in my future practice, I intend to conduct more research and attend courses in communication skills, safeguarding, and team work. I also intend to undertake intensive research and attend conferences, seminars, and trainings to improve my communication and leadership skills by December 2023."

50. In this regard, the Panel concluded:

"*Whilst noting your written submissions, the panel determined that you have not acknowledged that holding Patient A's door shut and detaining her causing her noticeable distress and emotional harm. Additionally, the panel was of the view that you have failed to demonstrate any remorse or reflected on your actions. The panel determined that you have shown limited insight and have failed to recognise the effect your actions had on colleagues or the nursing profession, or listening to staff on a ward that you were newly coming into. The panel determined that you have not provided any developing information to show what you would do if faced with a similar situation in the future.*"

51. Ms Rao submits that this criticism wrongly conflates insight with acceptance of the Panel's findings and that the Panel erred in:

    a. Failing to have regard to the relevant law on insight;

    b. Equating lack of remorse and acceptance of the Panel's findings with a lack of insight;

    c. Equating lack of insight with current impairment;

    d. Failing properly to read and understand the Reflection Piece provided;

    e. Without justification determining that the Registrant had not "provided any developing information to show what you would do if faced with a similar situation in the future" (the Registrant having submitted a Reflection which does exactly this);

    f. Failing to take account of the intervening 5 years during which no complaint of the Registrant's conduct has been made.

52. Mr Benzynie submitted, correctly, that the Panel is entitled to place emphasis or weight on the evidence before them and draw inferences from that evidence. Should those inferences be contrary to those of the Appellant or those submitted on the Appellant's behalf it does not make them impermissible. He pointed out, again correctly, that the Panel summarised the representations made on the Appellant's behalf. He emphasised the principles in *Sawati* that a registrant who denies impropriety makes it more difficult for him to demonstrate insight and that the court should be slow to interfere with the weighing exercise which the Panel has undertaken.

53. Accepting, as I do, the submissions made by Mr Benzynie, I remain unconvinced that the Panel engaged with the material before it, as these examples show. In my judgment, the Panel was wrong to:

    a. hold that the Appellant had failed to recognise the effect of his actions on colleagues, because he expressly does so in saying "*I can understand how colleagues were feeling when they formed the opinion that I was failing the patient"*

    b. state that no developing information was provided to show what the Appellant would do if faced with a similar situation. On the contrary, the Appellant explained that he was now aware of his limitations and would consult others if he found himself in a similar situation

    c. fail to explain how the intervening five years were relevant, or not, in that the Panel said nothing about the absence of any other complaint or concern which is evidently relevant to the question of future risk

    d. state that no remorse was shown, when in fact the Appellant explained the ways in which he was ashamed and his deep regret. I do not accept Ms Rao's submission that the Panel has wrongly equated lack of remorse with lack of insight. Rather, the Panel has baldly stated that no remorse was shown when it plainly was. That is a different circumstance to remorse being expressed but the

Panel rejecting it as false or manufactured.

54. Amongst these errors are echoes of the problems which are identified in Ground 1. Again, the Appellant's case has not been grappled with. This is not to say that each point required to be dealt with in detail. It did not. However, if clear findings are going to be made about recognising effects on others, how he has developed as a result of these events and whether there is remorse or not, the Appellant's evidence needs to be taken into account and at least some sense of the reason for rejecting it is necessary.

CONCLUSIONS AND DISPOSAL

55. The Appellant's case on both misconduct and impairment was largely omitted by the Panel in coming to its conclusions. In each respect, that case was underpinned by material, evidence and facts which raised serious issues about the situation which the Appellant had to deal with in the early hours of 28th November 2017. The Appellant is unable to understand from the Panel's reasons why his case was rejected. The appeal therefore succeeds on both grounds.

56. In those circumstances, when I circulated my draft judgment, I asked Counsel for submissions on the appropriate order. The court's powers include allowing the appeal and quashing the decision(s), substituting the decision(s) appealed against with any other decision(s) which the NMC could have made, and remitting the case with directions: Art 38(3) of the 2001 Order.

57. Mr Benzynie submitted that the case should be remitted to the Committee. The result, he submitted, was that the findings of fact were undisturbed, so far as they went, but that the findings of misconduct and impairment were quashed, along with the sanction. He points out that the Order remains suspended, albeit that the interim order has fallen away because its eighteen-month term has elapsed. The interim order was a sanction, but does not equate to penalty; it is an order in the public interest: *Abrahaem v General Medical Council* [2008] EWHC 183 (Admin), per Newman J.

58. Ms Rao seeks an order quashing the findings of fact. The findings of fact were reached wrongly. The factual findings cannot endure in the light of the court's decision, particularly paragraphs 43-45 above. Ms Rao draws attention to the fact that it is relevant that the interim order has been in place, to which the Appellant was subject. She seeks a simple order quashing the decision and submits that a decision on remittal will as a matter of fairness take into account whether any purpose would be served in the imposition of another order.

59. In a regulatory appeal for a health care professional, the primary focus is the public interest and trust as recognised by the NMC in articulating the role of the profession (paragraph 8 above). The competence of the regulatory body to judge professional standards lies with the regulatory body, not the court. The court must accord due deference to the evaluation of a panel composed of medical professionals who are obviously better placed to make a peer judgment: Thorpe LJ in *Meadow v GMC* [2006] EWCA Civ 1390; [2007] Q.B. 462 at [280]. Moreover, this appeal is on the papers without recall of witnesses.

60. I have found that the Panel was wrong to omit to make findings which related to the Appellant's case, to fail to integrate such findings on the issue of misconduct and to

omit important factors in finding impairment. My judgment in these respects is not based on the evidence of witnesses but on the basis of the same documents as were before the Panel. The circumstances faced by the Appellant on 28th November 2017 are clear and detailed and are easy for the court to see and understand. To that extent the court is as well placed to assess that material as the Panel. The court is similarly competent as the two lay members of the Panel but does not have the expertise of the registrant member of the Panel.

61. I am sure that if the Panel had taken the Appellant's case properly into account when it reached its decisions on misconduct, impairment and sanction, it would have reached different and less serious findings. It would either have found that misconduct was not made out, or that it was misconduct of a lesser degree. The same applies to impairment. The sanction would necessarily be a lesser sanction, or no sanction at all.

62. The interim order was made and has been effective during the period before this appeal. That interim order has now lapsed. I have not been told that there is any factor or fact which relates to events and the Appellant's practice post 2017 which warrants his return before the Committee. It is therefore clear that if the case were returned to the Panel, or a differently constituted panel, then no sanction could properly and fairly be imposed because the sanction has already served its purpose in the public interest.

63. In my judgment, in this case the public interest also includes the question of whether a full re-hearing of this particular case would be proportionate. I do not think that it would be. First, the outcome on sanction is highly likely to be 'no sanction' even if the Appellant's case was put to one side as happened before the Panel. Second, there is no evidence of any other regulatory concern in respect of the Appellant. Third, it is apparent from the Appellant's Reflective Piece at paragraph 49 above, that the experience and the fact of the proceedings had a substantial impact on his approach to his practice which, in my judgment, showed appropriate insight. Fourth, the re-hearing would have to be a complete re-hearing in order to establish the full factual matrix, rather than a short hearing on misconduct on the basis of the limited facts as found by the Panel.

64. Lastly, I would add that my decision on disposal is not taken in a vacuum. A deputy judge who sits in the Administrative Court encounters lists of applications by the Respondent to extend time to hear disciplinary charges from which it is clear that there is considerable pressure on the Respondent to address a large workload of serious cases, which the Respondent is working hard to complete. There is a risk that any remittal would take a considerable time to be heard, as is indicated by the hearing of this case before the Panel, i.e. five years. If I directed expedition, that would further delay other cases.

65. I decline to remit the case to the Respondent. I allow the appeal and quash the factual findings, the findings of misconduct and impairment, the sanction and resulting orders.

COSTS

66. There will be an order that the Respondent pays the Appellant's costs. I have assessed the Appellant's costs in the sum £8809. The work done on documents might have been undertaken by a solicitor other than a Grade A fee earner. However, well prepared bundles of documents are important for an efficient and fair hearing and I would not

wish to discourage care in that regard. Moreover, some aspects of the costs schedule are surprisingly low. In overview, the costs schedule is reasonable.