EXTRA DIVISION, INNER HOUSE, COURT OF SESSION

[2018] CSIH 51
XA94/17

Lady Paton
Lord Drummond Young
Lord Glennie

OPINION OF THE COURT

delivered by LADY PATON

in the appeal

by

JACQUELINE DALY

Appellant

against

THE NURSING AND MIDWIFERY COUNCIL

Respondents

Appellant: Party
Respondents: Anderson (sol adv); Nursing & Midwifery Council

26 July 2018

Appeal from a disciplinary procedure

[1] The appellant is a senior registered staff nurse with over twenty years experience. In 2015 she was employed by Virgin Care Limited at HM Prison Bullingdon, Norwich. Following certain incidents on 3 February and 2 March 2015, she was the subject of disciplinary procedures. Earlier in her nursing career, in 2011, she had received a caution order in respect of another matter.

[2] At a hearing in October 2017 before the Nursing and Midwifery Council ("NMC") Fitness to Practise Committee, the appellant faced three charges. She was represented by a barrister. Evidence was led from several witnesses: Cheryl Mortimer, Head of Healthcare at the prison; staff nurse Roseline Alichukwu, clinical team leader; staff nurse Andrew Nyabango, bank agency nurse; and Lloyd Mutseyekwa, primary care lead. A written statement from Martin Leach, staff nurse, was admitted as evidence subject to some qualifications (pages 6 to 7 of the committee's decision letter). The appellant gave evidence. Submissions were made, including a submission of "no case to answer" in respect of charge 1. That submission was rejected.

[3] In the committee's decision letter dated 12 October 2017, the following charges were found proved:

> "1. On 3 February 2015, [the appellant] failed to complete a Prisoner Escort Record ('PER') form for Prisoner A;
>
> 2. On 2 March 2015, [the appellant]
>
> 2.1 Discharged Prisoner B without referring him to an Assessment, Care in Custody and Teamwork ('ACCT') review;
>
> 2.2 Inadequately and/or inappropriately conducted an Assessment, Care in Custody and Teamwork ('ACCT') review for Prisoner C."

[4] The committee concluded that there had been misconduct and that the appellant's fitness to practise had been impaired. The sanction imposed was a 6 month suspension of registration, with effect from 10 November 2017.

[5] The appellant appealed to the Court of Session in terms of section 60 of the Health Act 1999 and articles 29(9) and 38 of The Nursing and Midwifery Order 2001. Those articles provide *inter alia*:

> "29(9) The person concerned … may appeal to the appropriate court against an order made under paragraph (5) and article 38 shall apply to the appeal …

38(1) An appeal from –

(a) any order or decision of the Fitness to Practise Committee other than an interim order made under article 31, shall lie to the appropriate court …

(3) The court or sheriff may –

(a) dismiss the appeal;

(b) allow the appeal and quash the decision appealed against …

(c) substitute for the decision appealed against any other decision the Fitness to Practise Committee … could have made …

(d) remit the case to the Fitness to Practise Committee … to be disposed of in accordance with the directions of the court or sheriff, and may make such order as to costs (or, in Scotland, expenses) as it, or he, as the case may be, thinks fit.

(4) In this article "the appropriate court " means –

(a) in the case of a person whose registered address is (or, if he were registered, would be) in Scotland, the Court of Session …"

[6] It was accepted that this was a full appeal, not restricted to points of law, or the type of review which might be expected in a judicial review. Guidance in relation to the scope of such appeals has been given in *Suddock* v *The Nursing and Midwifery Council* [2015] EWHC 3612 (Admin) paragraph 35; and *Hindmarch* v *The Nursing Midwifery Council* [2016] EWHC 2233 (Admin) paragraph 3. In particular, a court must be slow to interfere with findings of credibility and reliability, and any findings-in-fact based on such assessments. Further, special place must be given to the judgment of a tribunal such as the Fitness to Practice Committee in relation to findings which reflect a professional judgment concerning standards of professional practice and conduct.

[7] It was also accepted that the burden of proof rests on the NMC, and that the standard of proof is "on a balance of probabilities". Throughout the appeal, the appellant represented herself. The court was provided with *inter alia* a paginated folder containing a transcript of the evidence led, and other documents.

Charge 1: Prisoner A

[8] The evidence established that where a prisoner was to be transferred to court or to another prison, it was necessary to have a Prisoner Escort Record (PER) form completed and signed. The PER form gave details of the prisoner's circumstances, medical condition and medication, mental health, recent behaviour, and any risks such as self-harm or injury to others (folder page 67). A practice existed of completing a bundle of PER forms after midnight on the night shift, using information gleaned from computerised medical records. Some cases might, however, require a face-to-face interview with the prisoner.

[9] The evidence further established that on 2-3 February 2015, the appellant was on night shift (8.45 pm to 7.45 am). A handover between day and night shifts took place at about 9.00 pm on 2 February 2015, involving Ms Alichukwu and Mr Nyabango (day shift) and the appellant and Martin Leach (night shift). Having heard conflicting evidence, the committee found it proved that Ms Alichukwu handed a particular PER form relating to Prisoner A to the appellant and Mr Leach, and informed them that the line manager, Christian Mubaira, had specifically instructed that Prisoner A, who was being kept in a secure residential wing, was to be assessed in a face-to-face interview (folder pages 92, 96, 98 and 101). This instruction was apparently given because Prisoner A had killed his wife, and was thought to present a risk to himself and others. Ms Alichukwu gave evidence that, as the intention was to transfer Prisoner A to another prison at 7.30 am the following morning, the appellant should carry out the necessary face-to-face interview between 7.00 am and 7.30 am, when the prisoner was brought from his cell in the secure residential wing to Reception. The committee concluded that the task which the appellant was asked to complete was reasonable (decision letter page 9).

[10] The appellant gave evidence *inter alia* that it had not proved possible to carry out a face-to-face interview with Prisoner A. She had not attempted to do so overnight, and during the busy half-hour or so early in the morning at Reception, where many prisoners were being processed, she had not found or interviewed Prisoner A. Accordingly at the handover to the day nurses at 7.45 am, no face-to-face interview had been conducted, and Prisoner A's PER form had not been completed or signed. The appellant's understanding, as stated to this court, was that Prisoner A was not in fact brought to Reception until later that day, after 8.00 am. Mr Anderson for the respondents confirmed to this court that Prisoner A's transfer had been delayed, but there were no other known details about what had happened to him.

[11] There was some unclear evidence before the committee concerning a change of policy resulting in court transfer PER forms continuing to be completed by night staff, but not prison transfer forms. Also there was a question about the desirability of more general face-to-face interviews. However it is unnecessary to resolve these issues in this appeal.

[12] At the disciplinary hearing in October 2017, the appellant's barrister submitted *inter alia* that there was no case to answer in respect of the first charge. He argued that there was insufficient evidence to support a finding of a failure on the part of the appellant. That submission was rejected, for the reasons given by the committee.

[13] In the appeal to the Court of Session, we asked to be referred to any findings-in-fact or any evidence relating to the way in which Prisoner A was, in practical terms, to be made available to the appellant. We had in mind, for example, an established practice; or alternatively, particular arrangements made for Prisoner A. Our attention was not drawn to any such evidence or finding.

[14] In our opinion, the absence of such findings-in-fact and/or evidence did indeed result in no case to answer in respect of the first charge. For the appellant, as a night duty nurse, to be held to have "failed", in the sense of a failure in duty, to carry out the relayed instruction to have a face-to-face interview with Prisoner A before completing and signing his PER form ready for his transfer scheduled for 7.30 am the next morning, would in our view require proof of a recognised procedure whereby a prisoner could be located and safely interviewed face-to-face, and proof that the appellant knew of, but simply refused or failed to operate that procedure; or alternatively proof of particular arrangements which could realistically have been made in respect of Prisoner A, and that the appellant knew that such arrangements could be made but failed to avail herself of them. We assume that, during the night, prisoners in a secure residential wing are sleeping in their cells. To wake a prisoner at some time during the night or early morning, and to have him interviewed at an acceptable location with appropriate security, would appear to require such a recognised procedure or particular arrangements for a particular prisoner, both approaches requiring staff and security measures. Even if a night nurse was expected to conduct the face-to-face interview at some time between 7.00 am and 7.30 am during a busy period at Reception just before handing over to day staff (rather than attempting an interview some time earlier) it seems to us that some special arrangements would require to have been made and intimated to that nurse.

[15] Not only were there no findings-in-fact on the question of the practicalities of having a face-to-face interview with a high-risk prisoner overnight or early in the morning, but also some passages of evidence appeared to raise questions about whether such an interview could be regarded as normal practice and/or feasible. The following passages are examples.

[16] Ms Alichukwu, when asked in evidence-in-chief (folder page 93):

> "[On nightshift] how many times, if at all, have you had to do a PER yourself in this situation, where it was highlighted that you must see them face-to-face, they are high risk?"

replied –

> "Definitely not often. I can't remember. Not often."

[17] Martin Leach, the staff nurse working with the appellant on the relevant night, explained in his statement:

> "Both [the appellant] and I queried this [i.e. the relayed instruction requiring a face-to-face interview with Prisoner A before completing the PER form] as it was unusual … [The appellant] and myself explained that given the nature and duration of time night staff typically spend in Reception first thing in the morning, it was highly likely that we would not see [Prisoner A] …
>
> At no point was it mentioned that we should go across early or stay late specifically to see him – i.e. if he wasn't there when we were there … we would not be expected to see him, and presumably someone else from healthcare would review him if required …
>
> As it transpired, we were quite busy medicating inmates, and [the appellant] had to return to inpatients because there was not enough diazepam in Reception – this delayed us even more. As I recall [Prisoner A] was not present in Reception when we were there (and we did not leave until about 7.40) so we were unable to review him …
>
> With hindsight, it appears that [Prisoner A] was a transfer to another prison, and thus would have been expected to go through Reception later in the morning than the inmates going to court. As the role of night staff in the morning is to medicate and perhaps review inmates going to court, I wonder if it would have been more appropriate to have asked Hotel One to have reviewed [Prisoner A]? Certainly we would have seen him if he had been in Reception when we were present, but, unfortunately, he was not."

[18] Cheryl Mortimer, Head of Healthcare at the prison, agreed that she could not say that it was specifically the appellant's job to complete and sign the form (folder page 68). She confirmed that completion of a PER form could be an ordinary part of a night shift or a day shift (folder page 58). At page 73, the following exchange was recorded:

> "Q. The normal procedure you have mentioned is that the nightshift will advise the dayshift. Is it normal that the nightshift might not be able to do

everything, and the dayshift would have to then pick up any work that was not yet completed?

A. Yeah, sometimes. Depending on how busy the units are at night, things can be handed over the next day. It's twenty-four hour care, so it can be moved over to the following shift if needed."

[19] In the result we have concluded that, on the basis of the evidence available to the committee and on the basis of their findings-in-fact, no reasonable committee could have concluded as a question of mixed fact and law that the appellant "failed" (in the sense of failed in a duty such as might amount to misconduct) to complete a PER form for Prisoner A. It is a fact that she did not complete such a form. But it seems to us, first, that Mr Mubaira's relayed instruction was, on the evidence available (and in particular in the absence of evidence of a procedure or arrangements, as set out in paragraph [14] above), not one which was standard or easily manageable; secondly, that it was recognised that, depending upon the burden of work on the night shift, tasks unfinished by night staff became work to be done by the day staff; and thirdly, that the transfers of prisoners to court took priority over the transfers of prisoners to other prisons, thus making Prisoner A's case *prima facie* less urgent than others.

[20] In our view therefore there was indeed no case to answer in respect of charge 1. The committee erred in law in refusing the appellant's submission to that effect. Our conclusion is not based upon any challenge to or criticism of the findings-in-fact made by the committee (cf the guidance given in *Suddock* v *The Nursing Midwifery Council* and *Hindmarch* v *The Nursing Midwifery Council*). Rather it is the lack of evidence, and the lack of related findings-in-fact, about the practicalities of a face-to-face interview with a high-risk prisoner at some time during the night shift, or between 7.00 am and 7.30 am at Reception, which has led us to form the opinion we have.

[21] We shall therefore allow the appeal insofar as relating to charge 1. We shall quash the committee's decision in respect of charge 1.

Charge 2.1: Prisoner B

[22] At the disciplinary hearing in October 2017, the appellant admitted the facts constituting charge 2.1. The case presenter (folder page 53 *et seq*) explained to the committee that an Assessment, Care in Custody and Teamwork review (an ACCT review) was an important part of safeguarding a patient/prisoner. It was a multidisciplinary review, conducted for any patient identified as being at particular risk. A review should take place at regular intervals, and also when a particular event was to take place such as the discharge of a prisoner from a healthcare wing to an ordinary location.

[23] In her witness statement dated 10 April 2017 (folder page 281 *et seq*), adopted as part of her evidence, Cheryl Mortimer explained the circumstances as follows:

> "11. An ACCT document is an orange booklet, to safeguard the wellbeing and safety of vulnerable and high risk prisoners who may have a high risk of suicide or self-harm. The document logs case reviews and lists the set observations that a prisoner requires. It is a joint document that is maintained by both healthcare and prison staff.
>
> 12. Prisoner B was due to be moved on to a normal wing. Anybody with an ACCT document requires to have a review prior to transfer; this review meeting is a multidisciplinary meeting to discuss the discharge of the prisoner from the unit to a normal wing of the prison to establish if they still pose a risk to self or other; an ACCT review meeting should be organised to take place within 24 hours of the planned transfer. The document follows a patient wherever they go.
>
> 13. As I understand [it], there had been a discussion between [the appellant] and the prison GP that Prisoner B was fit to be discharged from the unit he was in. However this was on a medical basis only, and there had been no consideration of the operational impact. An ACCT review meeting was not arranged to take place and it was only picked up that this had not happened when Prisoner B was moved to a new wing on 2 March 2015. [The appellant]

had actioned the move and admitted in interview that Prisoner B had been moved without completion of the appropriate ACCT review …

14. There were risks associated with this incident: Prisoner B was on an ACCT due to previous self-harm so the risk factors in relation to this patient were high anyway, but in light of the review not taking place, the risk to Prisoner B could have been further compromised as there was no communication from the healthcare to the prison staff to notify them of any changes in Prisoner B's activity or daily routine. Such communication is important …"

[24] In the appeal hearing, the appellant put forward certain factors in mitigation (folder pages 240 *et seq*, and her oral submissions in the appeal). We record those factors below, although noting that there appears to have been no reference to the Separation, Support and Challenge Unit (SSCU) in the course of Ms Mortimer's cross-examination.

[25] The appellant stated that she had not been familiar with day duties as she had been working on night shift as arranged in order to assist with her care of her ailing father. Following upon the difficulty with Prisoner A on 3 February 2015, she had been suspended from night duty and directed to work her contracted hours on day duty. The incidents on 2 March 2015 occurred during a week which had been designated as a "training and up-dating week", but which, as a direct result of staff shortages, turned out to be a week of full day duties for her.

[26] In relation to charge 2.1, the appellant advised that Prisoner B was situated in inpatients in the healthcare wing. He had been violent and aggressive. He had taken "spice", which he told the appellant and the examining doctor he had done for his own entertainment, not for self-harm. The prisoner was to be sent to the Separation, Support and Challenge Unit (SSCU). The appellant further advised the court that, unlike the discharge of a prisoner into a standard cell in a secure residential unit, a prisoner who was destined for the SSCU could be sent directly to the SSCU and be reviewed there. What was missing in

the paperwork in Prisoner B's case was a referral completed in such a way as to ensure that the prisoner would indeed be reviewed when he arrived at the SSCU. The result of that missing document was that when Prisoner B arrived at his destination, escorted by prison officers, he was sent back because there had been no ACCT review. There had been little risk to anyone, including Prisoner B, as a result of the incident.

[27] Mr Anderson for the respondents confirmed that the omission had been quickly identified. Prisoner B had been returned to his original unit where the ACCT review was carried out. Apart from inconvenience to B and prison staff, there had been no harm suffered.

[28] The tribunal's ruling in respect of charge 2.1 therefore stands. However the mitigating circumstances advanced by the appellant may have some relevance to the outcome of this appeal.

Charge 2.2: Prisoner C

[29] The evidence established that on 2 March 2015, Prisoner C was being discharged from inpatients to a normal wing. There had to be an ACCT review whenever a prisoner was returned to an ordinary location after being held in a healthcare wing.

[30] It appears that there were staff shortages that day, resulting in the appellant's chairing of this particular ACCT review. Before the committee, the appellant successfully rebutted an assertion that she was "not qualified to chair" an ACCT review.

[31] In relation to the charge that the appellant "inadequately and/or inappropriately conducted" an ACCT review for Prisoner C, the evidence established that the paperwork signed off by the appellant after the review was later found to contain an incomplete form.

The committee reached their decision on the basis of the incomplete page (folder page 367) and their views on credibility.

[32] Before us, the appellant submitted that the decision should have been one of "not proven". Ms Mortimer had not made her investigation until about 5 months later, and the prisoner's file comprised a loose bundle of papers held together by a treasury tag, which had been used by various members of staff over that period. If the committee's decision were to stand, the appellant invited the appeal court to take into account the following mitigating circumstances:

- The appellant had expected to be participating in a "training and up-dating" week. However because of staff shortages, she was given full day duties, which she was not used to.
- The appellant remembered the prisoner well: the review had been a particularly thorough one.
- The filling-in of the form had been commenced, but for some reason had not been completed. The half-completed form should have been shredded.
- The appellant could not explain why the incomplete form was in the prisoner's file. Nor could she explain where any completed form could have been found.
- The appellant described the incident as a genuine simple error.

[33] In our opinion, on the basis of the findings-in-fact and underlying evidence, and bearing in mind the committee's views on credibility (decision letter page 8), it is not open to this court to criticise the committee's decision that charge 2.2 was proven.

Decision

[34] For the reasons given earlier in this opinion, we allow the appeal in part and quash the finding in respect of charge 1, namely that on 3 February 2015, the appellant failed to complete a Prisoner Escort Record ('PER') form for Prisoner A.

[35] The findings in respect of charges 2.1 and 2.2 remain. As they represent two out of the three initial charges which led to suspension for 6 months, we consider that it is open to us to re-assess questions of misconduct and sanction.

[36] We take no issue with the view that there was misconduct. However, having regard to the public interest, and what might be necessary to protect the public, we are not satisfied that what remains as proven against the appellant amounted to misconduct of such a nature that the appellant's fitness to practise was impaired in terms of article 22 (1A) of the Nursing and Midwifery Council Order 2001 (cf *Hindmarch* v *NMC* [2016] EWHC 2233, and the approach and authorities therein). We consider that the conduct in question falls at the lower end of the range of possible short-comings, errors, negligence, or deliberate wrong-doing by a registered staff nurse. Further we consider that in the appellant's case there were mitigating circumstances, outlined above. Ultimately we have concluded that the sanction imposed was excessive, even taking into account the previous matter in 2011, the details of which are unknown to this court but which was accepted by the appellant to be "serious", and which attracted the sanction of a caution order. We shall therefore allow the appeal so far as directed against sanction; quash the suspension order, and substitute therefor a conditions of practice order on the appellant's registration, namely a condition that the appellant must undertake a recognised "Return to Practice Nursing Course". We understand that the appellant must undertake such retraining in any event, as she has not worked as a nurse since March 2015.

[37] We continue any question of expenses.