Conduct and Competence Committee
Substantive Hearing
26 May 2017
Nursing and Midwifery Council, 2 Stratford Place, London E20 1EJ

Name of Registrant Nurse: Giles Rigby

NMC PIN: 92C0592E

Part(s) of the register: RN5, Registered Nurse (sub Part 1)
Learning Disabilities (14 May 1995)
RNMH, Registered Nurse (sub part 1)
Mental Health (25 April 1998)

Area of Registered Address: England

Type of Case: Misconduct

Panel Members: Joy Julien (Chair, Lay member)
Emily Young (Registrant member)
Hildah Jiah (Registrant member)

Legal Assessor: Michael Epstein

Panel Secretary: Vicki Watts

Mr Rigby: Not present and not represented

Nursing and Midwifery Council: Represented by Hannah Smith, Counsel, NMC Regulatory Legal Team

Facts proved: All by admission

Fitness to practise: Impaired

Sanction: Caution Order – 3 Years
Decision on Service of Notice of Hearing:

The panel considered whether service of the notice of this hearing had been effected in compliance with Rules 11 and 34 of the (Nursing and Midwifery Council) NMC Fitness to Practise Rules 2004 (the Rules). Notice of today’s hearing was sent by recorded delivery and first class post to Mr Rigby’s registered address on 5 April 2017.

The panel accepted the advice of the legal assessor.

The panel was satisfied that notice of the hearing was duly served in accordance with the Rules and that 28 days notice had been provided.

Decision on proceeding in absence

Ms Smith, on behalf of the Nursing and Midwifery Council (NMC), made an application to proceed in the absence of Mr Rigby. She referred to email correspondence from Mr Rigby’s representative at the Royal College of Nursing (RCN), dated 19 May, from which it is apparent that Mr Rigby is aware that the hearing is taking place today, and has chosen not to attend, or be represented in his absence. Ms Smith also referred the panel to an email from the RCN on 26 May 2017 which requests an update of the panel’s decision on the CPD as Mr Rigby is “anxious to find out”.

The panel accepted the advice of the legal assessor.

The panel was mindful that there is a clear public interest in dealing with this matter expeditiously, and that no adjournment has been sought by Mr Rigby. The panel was made aware that the hearing today will deal with a consensual panel determination (CPD) proposal and that Mr Rigby had agreed for the panel to consider this in his absence.
The panel concluded that no useful purpose would be served by an adjournment and that it would be fair, and in the interests of justice and Mr Rigby, to proceed with the hearing today in his absence.

**Consensual panel determination:**

At the outset of the hearing Ms Smith on behalf of the NMC, provided the panel with a Consensual Panel Determination: provisional agreement ("CPD") document. The CPD was signed by Mr Rigby and the NMC on 26 May 2017. Ms Smith submitted that the agreement provided a proportionate and appropriate disposal for Mr Rigby’s case.

Ms Smith detailed the facts as set out in the CPD document and guided the panel through the document. She referred to the mitigating and aggravating factors and invited the panel to accept the agreement in full.

The CPD reads as follows:

**Conduct and Competence Committee**

"Consensual panel determination: provisional agreement"

Mr Rigby is represented by the RCN, and is aware of the CPD hearing. Neither Mr Rigby nor his representative, Mr Cheesman, intend to attend the hearing and Mr Rigby is content for it to proceed in his and his representative’s absence. Mr Cheesman will be available by telephone should any clarification on any point within this agreement be required.

The Nursing and Midwifery Council and Mr Giles Rigby ("the Registrant") PIN: 92C0592E ("the parties") agree as follows:

**Charges**

1. The Registrant admits the following charges:
That you, while employed as a registered nurse by Bradford District Care NHS Foundation Trust:

1. Failed to maintain a professional relationship with Patient A in that you:

   1.1. Visited Patient A at Mulberry House on 2 September 2015 with Colleague A.

   1.2. Visited Patient A at Mulberry House on 7 September 2015 with Colleague A.

   1.3. Obtained Patient A’s personal mobile phone number.

   1.4. Gave Patient A your personal mobile phone number.

   1.5. Gave Patient A gifts.

2. Did not inform your line manager of your intention to carry out any or all of the acts outlined in charge 1 prior to you carrying each or any of them out.

3. Did not yourself tell your line manager that you had failed to maintain a professional relationship with Patient A, as outlined in charge 1 above, prior to your line manager discovering this from a third party on or around 8 September 2015.

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

Background/Facts

2. The facts are as follows:

   2.1. The Registrant was employed by Bradford District Care NHS Foundation Trust (“the referrer”) as a Band 5 staff nurse at Daisy Hill Intensive Therapy Centre from 11 May 2015 to 10 September 2015.
2.2. On 2 September 2015, the Registrant was observed visiting his former patient, Patient A, along with his colleague, Healthcare Assistant A (‘HCAA’), at Mulberry House where she was in receipt of inpatient treatment. Patient A had previously been under the care of the Registrant while she was an inpatient at Daisy Hill Intensive Treatment Centre (“ITC”) and had been discharged from the ITC in August 2015. Patient A was a 20-year-old woman with a diagnosis of borderline personality disorder who had been admitted to ITC for further in-depth assessment. She was a very vulnerable patient who had difficulties in engaging with professionals and had attachment issues.

2.3. The Registrant admits that, following Patient A’s discharge, he obtained Patient A’s telephone number from another patient and text messaged Patient A and asked whether she would be happy if he and HCAA came to visit her. He subsequently visited Patient A with HCAA on two occasions. He admits that he took Patient A gifts of cigarettes and coca cola and that he and HCAA offered to take Patient A to a clinic at Acer House on their day off. The Registrant admits stating, when challenged, ‘I threw professionalism out of the window ages ago, I am a human being first before I am a professional.’ The Registrant and his colleague also suggested to Patient A that she could return to the ITC once she had completed her therapy work at the Acer Clinic and Mulberry House.

2.4. The Registrant’s line manager, Patrick Harper, spoke to him on 8 September 2015 about his visits to Patient A and the Registrant acknowledged that he had visited Patient A on two occasions, for two hours on 2 September 2015 and for one hour on 7 September 2015, and that he had initiated contact with Patient A following her discharge from the ITU. The Registrant also stated that he had given his personal mobile number to Patient A and confirmed that he was also in possession of Patient A’s mobile number. He confirmed he had taken Patient A gifts of cigarettes and coca cola. When asked why he didn’t discuss with the team he stated he didn’t know how people would feel and he didn’t think it would go down very well.
2.5. During a second face to face meeting on 9 September 2015, the Registrant stated that Patient A reminded him of his own daughter and expressed no contrition for his actions. He acknowledged that he had encouraged HCAA to visit with him as he needed her to be there as Patient A is afraid of men. He was subsequently dismissed from the Trust on 10 September 2015 and referred to the NMC on 14 September 2015.

Misconduct

3. The Registrant admits that the facts described at paragraph 2 of this agreement amount to misconduct having regard to Roylance v General Medical Council (No.2)[2000] 1 A.C. 311, in which Lord Clyde stated “misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.”

4. Not every breach of the code, and not every falling short in the particular circumstances, will amount to misconduct. It must be serious or, as Elias LJ put it in the case of R (on the Application of Remedy UK Ltd) v GMC [2010] EWHC 1245 (Admin), “sufficiently serious….that it can properly be described as misconduct going to fitness to practise.”

5. The Registrant accepts that he did not maintain professional boundaries with Patient A and acted in a way that was unprofessional. He accepts that he let his personal concerns take precedence over his professional responsibilities, and that he lost his objectivity as a nurse. He accepts he should have dealt with his concerns by going through the appropriate channels, such as raising his concerns about Patient A’s wellbeing with management or other clinicians. He accepts that by not doing this, and taking matters into his own hands, his conduct fell below what would be proper in the circumstances, and was serious in that his actions created a risk of harm to Patient A, a highly vulnerable patient.
6. The parties agree that the Registrant’s conduct was tantamount to a breach of the following sections of the 2015 edition of the NMC’s code:

**16 Act without delay if you believe that there is a risk to patient safety or public protection**

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other healthcare setting and use the channels available to you in line with our guidance and your local working practices

**20 Uphold the reputation of your profession at all times**

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

**Impairment by reason of Misconduct**

7. The Registrant admits that his fitness to practise is impaired by reason of his misconduct on the grounds of public interest.

8. With reference to the factors outlined by Dame Janet Smith in the 5th Shipman Report, the Registrant admits that he:

   a. Has in the past acted so as to put a patient at unwarranted risk of harm;
   b. Has in the past brought the profession into disrepute;
   c. Has in the past breached one of the fundamental tenets of the profession.

9. The parties agree that the misconduct placed Patient A at a risk of harm and could have had an adverse effect on her. Patient A was a vulnerable patient who may have perceived the relationship as a personal one and more of a friendship, rather than a professional relationship, as a result of the Registrant’s actions. This was
particularly an issue given her mental health state and attachment issues. The Registrant fully recognises the potential harm caused by his breaching professional boundaries and maintaining contact with a vulnerable patient after she had been discharged from his care, and the power imbalance between himself, a registered professional, and Patient A, a vulnerable patient.

10. The parties agree that the Registrant’s actions, while inappropriate, were motivated out of his concern for Patient A’s wellbeing. He had no sinister motive in visiting Patient A. At no point did the Registrant attempt to conceal his identity, the fact that he was a nurse, or his place of work. It was at no time his intention to expose Patient A to a risk of harm or to cause her distress. He did not wish to take advantage of Patient A’s vulnerability but to assure himself that she was receiving good care at the acute ward. He believed at the time, albeit wrongly, that he was acting in Patient A’s best interests. In order to give context to the incident, the parties make reference to sections 1.3, 3.1 and 3.1.3 of the ITC Service Model (Appendix 3), which sets out the ‘Therapeutic Community’ model in which the Registrant was working, and under which Patient A had been receiving treatment, at ITC. The parties in no way consider this to be an excuse for the Registrant’s inappropriate behavior, but consider that it provides context for the development of his relationship with Patient A and his concerns for her wellbeing following her discharge, which at the time had caused the Registrant concern.

1.3 Therapeutic Community
Daisy Hill ITC provides an intensive programme of Psychological Therapy within a carefully planned Therapeutic Community (TC), implement the principles and practice of Group Schema Therapy. Our overall objective is to encourage and enable all members of our community to develop and grow the healthy aspects of their personality. As such, our overall treatment approach involves harnessing the value of social and group processes within a communal environment analogous with that of a healthy family. In accordance with the principles of TC as set out by the Royal College of Psychiatry we promote equitable group living – both staff and resident members – are valued equally and encouraged to participate in decisions affecting the whole community. We encourage our members to form trusting relationships and to openly discuss emotional issues. We promote a genuine, open attitude from our staff members, so that the consequences of actions are confronted in an empathic manner...
3.1.2 Attachment

...The Centre prioritises the development of secure attachments between members and with staff, within the values and limits of a Therapeutic Community (Appendices 1 & 2). The community acts as a surrogate “family” from which each individual may develop a healthy and autonomous sense of self. Normal emotional needs – such as those for connection, openness, validation, warmth, care, adequate limits and autonomy – may thus be met within our therapeutic environment. Feelings of dependency or members “neediness” are not pathologized, but recognised as an opportunity to learn about normal needs and how to meet them. Members learn to understand the impact of their behaviour on other individuals and the community, and about balance in relationship. This day-to-day interactions with staff and other members become an opportunity for repairing deep psychological wounds, such as fears related to abandonment, neglect, mistrust and isolation.

3.1.3 Limited Reparenting within Health Community Family

Staff adopt a “limited reparenting” role within the community. This involves a warm and genuine stance towards members, with staff members acting in many regards as a good parent would towards a child, within the boundaries of a therapeutic relationship (Young et al. 2003; Farrell & Shaw, 2012). Paralleling the experience of a healthy family, the intention is to ensure that all members of the community feel included, cared for and valued...

11. It is noted that prior to visiting Patient A the Registrant took steps to safeguard her (such as making sure he did not visit her alone, taking a female colleague with him); in addition he only visited her in a clinical environment and did not, for example, visit her at home or socially. Although he did not volunteer what he had done to his employer, when invited to a meeting with his manager he was forthcoming about what had taken place.

12. The parties agree that the Registrant’s actions arose out of a particular set of circumstances and could be described as an isolated incident in an otherwise lengthy career with no previous (or subsequent) regulatory intervention. The Registrant recognises that he made a mistake in going beyond his professional boundaries, and has demonstrated a high degree of remorse and insight into his actions. He has addressed the deficiencies in his practice through undertaking a period of reflection and completion of research into maintaining professional
boundaries in the workplace and articulating lessons learnt in a reflective piece (see Appendices 1 and 2). The risk of repetition is considered to be low, if not remote, in all the circumstances. It is nonetheless agreed that, further to the decision in Council for Healthcare Regulatory Excellence v (1) NMC & (2) Grant [2011] EWHC 927, there is a need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession, and in the NMC as regulator. The parties therefore agree that a finding of current impairment on the grounds of public interest alone is warranted.

13. The registrant admitted his actions to his employer at the time, and has engaged with the NMC throughout these proceedings. He accepts that when initially challenged by his employer his responses were guarded, and he accepts that it would have appeared that he lacked insight into his actions and the consequences of them, noting in his reflective piece that:

A day or two after this I was contacted at home by the lead therapist who requested to see me, so I stopped on after my night shift to see him the following day, during this meeting he asked me specific questions about what had occurred during the visit, all of which I answered honestly, also during the meeting it became apparent to me that my actions had not been appreciated by the lead therapist, so I became guarded in my responses, I guess this is why I was perceived as lacking insight into my actions, during this meeting I offered to resign as I did not want my actions to reflect badly on the service.

A day or so later I was asked to attend a meeting with the assistant director of specialist services and a representative from human resources, during which I was asked similar questions to those in the previous meeting again I answered honestly, but was again guarded in my responses as I knew my employment was about to be terminated, which it subsequently was.

I have had a lot of time to reflect on these events and accusations and can see how it would appear that I lacked insight into my actions and the consequences of them. I think at the time I was acting as I thought a member of the community should act and was concerned about the safety of another member and wanted to ensure that they were safe.

14. Since the initial meeting with his employer, the Registrant has displayed developing insight into his actions, and has continued to update his reflections throughout the
NMC process. In his most recently updated reflective piece the Registrant demonstrates his further, developed, reflection on these events, stating:

At the time I thought I was acting in this way but now realise that I was doing this from a personal perspective and not a professional one, by this point my professional boundaries had become blurred and I was acting on instinct rather than professional judgement.

The original complaint against me, made to my managers was in relation to a comment I had made during one of the visits I had made to the patient in question about putting my humanity above my professionalism, this was an off the cuff, throwaway comment made to put the patient at ease as she was quite distressed. (she was distressed due to being assessed for another placement and it was the assessor that made the complaint to my managers) With hindsight I should never have made the comment at all, the colleague who was with me knew what I meant, however the assessor who made the complaint had never met me before and did not understand my comment and they acted accordingly. The comment was not made with the intention of denigrating the nursing profession but more to try and level out the professional/patient divide and put her at ease. Where I ever in a similar situation I would give a more considered response given that there were people there who could not have known my intent.

As a nurse objectivity has always been important to me, to be able to judge fairly and remain impartial, for the general public to know that they can trust us with their care and that we will remain objective whilst giving such care to ensure that everyone is treated equally. Unfortunately on this occasion I was not objective in my professional capacity and let my personal concerns outweigh my professional responsibilities.

I accept responsibility in acting the way that I did, at the time it seemed that only course of action open to me, on reflection, the correct course of action would have been to wait until I was back on day shift and raised my concerns with my manager and taken it from there. Having never been in such a situation before I honestly did not know what else to do. In my experience discharge had always been a planned process involving the MDT.

The patient in question was an extremely vulnerable young woman who amongst other things had issues with attachment, being discharged from an environment where she had just begun to build relationships was in my view wrong, so I took it upon myself to maintain contact and offer some stability/consistency in her life, My visits to her were part of this. With the benefit of hindsight I can see how my actions may have had an adverse effect on the patient as she may have perceived the relationship as a personal one and more of a friendship than a professional relationship. A fact which may have caused her further distress and could have jeopardised her recovery as well as the reputation of my employer and the overall reputation of the nursing profession a fact that concerns me on a daily basis.
I would find it difficult to quote passages from the NMC code of conduct in support of my appeal against the allegations made against me, because as I have stated previously at this point I was acting on personal concerns rather than professional responsibilities, although I was in my view putting people first and attempting to preserve safety, but due to circumstances did this outside the role of a professional nurse.

Being a nurse means a lot to me and I have been doing it for almost twenty five years, during this time I have never had complaints or allegations raised against me, until now and am finding it really hard. I accept that I was in a privileged position and my colleagues may have perceived me as a role model (because of my experience) and am truly sorry that I did not act as you would expect someone of my experience to act, i.e. in a professional manner and my actions are not ones I would wish others to replicate in the future. I accept that I overstepped my professional boundaries and regret doing this and would like to apologise to the patient in question, my former colleagues and former employer, the NMC and wider nursing profession and I make this apology unreservedly. I have learned a lesson in all of this and will never again overstep my professional boundaries, where I to find myself in a similar situation.

Sanction

15. The appropriate sanction in this case is a 3 year caution order.

16. This case involves a failure to maintain professional boundaries with a highly vulnerable patient. Although there is no evidence that the Registrant’s actions did cause any harm to Patient A, there was a clear risk of harm to the patient, and to the reputation of the profession, as a result of the Registrant’s actions, and he has breached fundamental tenets of the profession as expressed in the Code. Given the need to maintain proper standards of conduct and public confidence in the profession, to take no further action would be neither sufficient nor proportionate.

17. A caution order is the appropriate sanction in this case. Paragraph 60 of the Indicative Sanctions Guidance sets out that a caution may be appropriate where the case is at the lower end of the spectrum of impaired fitness to practice and the panel wishes to mark that the behavior was unacceptable and must not happen again. It is agreed that this the facts of this case sit within that definition.

18. Given the Registrant’s practice history of nearly 25 years with no other regulatory intervention, and the particular circumstances of this case, the panel can be
confident that there is no risk to the public or to patients which requires the Registrant's practice rights to be restricted. A caution order for 3 years marks that the Registrant's behavior was unacceptable and satisfies the public interest in maintaining confidence in the profession and the NMC as regulator, and is proportionate in the circumstances.

19. A conditions of practice order would not be appropriate in this case. There is no evidence of any deep-seated personality or attitudinal problems, and no identifiable areas of the Registrant's practice in need of assessment or retraining. There is no evidence of general incompetence or that there is any need to protect patients.

20. Having regard to paragraphs 65 to 69 of the Indicative Sanctions Guidance, it is considered that the Registrant's misconduct, while serious, and a departure from the standards to be expected of a nurse, is not fundamentally incompatible with him continuing to remain on the register. To remove the Registrant from the register either temporarily or permanently would be disproportionate in this case.

The parties understand that this provisional agreement cannot bind a panel, and that the final decision on findings impairment and sanction is a matter for the panel. The parties understand that, in the event that a panel does not agree with this provisional agreement, the admissions to the charges set out above, and the agreed statement of facts set out above, may be placed before a differently constituted panel that is determining the allegation, provided that it would be relevant and fair to do so.

Signed ...........................................  Dated ...........................................
Giles Rigby

Signed ...........................................  Dated ...........................................
(For and on behalf of the NMC)
**Decision and reasons on the proposed consensual panel determination:**

The panel accepted the advice of the legal assessor.

The panel had sight of the appendices to the CPD consisting of Mr Rigby’s updated reflection, details of information on professionalism read by Mr Rigby and Daisy Hill Intensive Therapy Centre Service Model.

The panel found the facts of the case proved by way of Mr Rigby’s admission, as set out within the CPD.

The panel noted that the referrer has provided a response to the proposed CPD agreement, making clear that she on behalf of the trust is content with the outcome.

Mr Rigby has admitted that his actions amounted to misconduct and that his fitness to practise is currently impaired.

The panel determined that the facts found proved by way of admission constituted breaches of the NMC 2015 Code of Conduct as set out in the CPD. The panel was satisfied that Mr Rigby’s actions fell below the standards expected of a registered nurse.

The panel was in agreement with the CPD that the facts in this case were such that public confidence in the nursing profession would be seriously undermined if a finding of impairment were not made. The panel considered that Mr Rigby’s’ full admissions and acceptance of the CPD agreement, together with his detailed reflection, demonstrated insight into the charges, and an acceptance of how his misconduct impacted on a vulnerable patient and upon the wider nursing profession. The parties therefore agree with the CPD that a finding of current impairment on the grounds of public interest alone is warranted.

The panel accepted the aggravating and mitigation factors as set out in the CPD. The panel considered in light of Mr Rigby’s detailed reflection, there was a minimal risk of repetition.
The panel proceeded to consider sanction and had in mind the NMC’s *Indicative Sanctions Guidance*. It agreed that to take no further action in this case would be insufficient to maintain public confidence in the nursing profession and the NMC as its regulator.

The panel next considered a caution order. The panel took into account Mr Rigby’s 25 year unblemished career as a nurse and his engagement with the NMC. The panel considered the reflection he has provided for this hearing was detailed and in the panel’s view it is evident that he has thoroughly reflected on his misconduct. The panel particularly noted that Mr Rigby states:

“With regard to the risks to patient in this instance, it is important to maintain professional boundaries to ensure that appropriate, therapeutic relationships are maintained and to ensure that the patient is aware of this and knows their role in the relationship. My actions were motivated by personal concerns and subsequently could have been perceived by the patient in this light and result in expectations that are unrealistic and subsequently damage further therapeutic relationships, the patient in question did have issues around attachment and my actions may have compounded these. I have had a long time to reflect on my actions and sincerely regret having taken the course I did, but again as I have stated previously it was done out of genuine concern for patient safety”.

The panel considered that Mr Rigby has recognised his failings and accepted that his fitness to practise is impaired and that a three year caution order is appropriate. The panel considered that a caution order may be appropriate where there is a need to mark the behaviour as unacceptable, and must not happen again. The panel was of the view that a caution order, for three years, would be appropriate in that it would address the public interest by sending a clear message of the standards expected of nurses.

The panel has therefore determined that it agrees with the CPD and has decided to make the order set out in the provisional agreement.
Mr Rigby’s record in the NMC register will show that he is subject of a caution for a period of three years and anyone who enquires about his registration during that period will be informed about the order.

That concludes this determination.