Nursing and Midwifery Council

Fitness to Practise Committee

Substantive Order Review Hearing

2 May 2019

Nursing and Midwifery Council, 2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of registrant:	Andrew Thomas Smyth
NMC PIN:	81Y2974E
Part(s) of the register:	Registered Nurse – Adult (Level 2) Adult Nursing (March 2002)
Area of Registered Address:	England
Type of Case:	Misconduct
Panel Members:	Anne Asher (Chair, Registrant member) Laura Wallbank (Registrant member) Chris Thornton (Lay member)
Legal Assessor:	Hassan Khan
Panel Secretary:	Calvin Ngwenya
Nursing and Midwifery Council:	Represented by Richard Webb, Case Presenter.
Registrant:	Mr Smyth was not present nor represented
Order being reviewed:	Suspension order (6 months)
Fitness to Practise:	Impaired
Outcome:	Striking-Off Order to come into effect on 22 May 2019 in accordance with Article 30 (1).

Service of notice of hearing:

The panel was informed at the start of this hearing that Mr Smyth was not in attendance and that written notice of this hearing had been sent to Mr Smyth's registered address by recorded delivery and by first class post on 27 March 2019. The notice was delivered and signed for on 28 March 2019.

The notice letter provided details of the time, date and venue of the hearing and, amongst other things, information about Mr Smyth's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence. Mr Webb submitted that the NMC had complied with the requirements of Rules 11 and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ("the Rules").

In the light of all of the information available, and having heard the advice of the legal assessor, the panel was satisfied that Mr Smyth has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34.

Proceeding in absence:

The panel then considered whether to continue in the absence of Mr Smyth.

The panel took account of the submissions made by Mr Webb. The panel also heard and accepted the advice of the legal assessor. The panel was mindful that to proceed in the absence of a registrant is a discretion that must be exercised with the utmost care and caution.

Mr Webb invited the panel to exercise its discretion and proceed in the absence of Mr Smyth. Mr Webb submitted that there had been no response to the notice from Mr Smyth and his last contact was on 23 October 2018, when he indicated that he was not attending the hearing on that occasion. Mr Webb submitted that in light of Mr Smyth's disengagement, the panel should proceed on the grounds of public interest and the expeditious review of the order due to expire on 22 May 2019.

The panel heard and accepted the advice of the legal assessor.

The panel noted that Mr Smyth had been sent the notice of hearing and should be aware of today's proceedings. However, he has not offered any explanation for his non-attendance and his last contact with the NMC was in October 2018. The panel concluded that Mr Smyth had voluntarily absented himself and disengaged from the regulatory process. The panel bore in mind that there is a statutory requirement that this order be reviewed before its expiry in accordance with Article 30 (1). Having weighed the interests of Mr Smyth with those of the NMC and the public interest in the expeditious disposal of this hearing the panel determined to proceed in Mr Smyth's absence.

Decision and reasons on review of the current order

The panel decided to replace the current suspension order with a striking off order. This order will come into effect at the end of 22 May 2019 in accordance with Article 30(1) of the Nursing and Midwifery Order 2001 (as amended) (the Order).

This is the second review of a suspension order, originally imposed by a panel of the Fitness to Practise Committee on 19 October 2017 for 12 months. The order was reviewed and extended by a further 6 months at a review hearing on 26 October 2018. The current order is due to expire at the end of 22 May 2019.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved which resulted in the imposition of the substantive order were as follows:

> That you a registered nurse whilst working in the capacity of Home Manager of Barrington Lodge Care Home ('the Home'):
>
> 1. Employed Colleague A:

a. Without first conducting adequate checks on the reason for his NMC caution.

b. Without making any or any adequate enquiries of a previous employer into the reason for his dismissal.

c. Without consulting the Human Resources department and/or senior management at the Home in relation to Colleague A's NMC caution, and/or his previous dismissal and/or poor reference(s).

2. Between 3 July 2016 and 5 July 2016, failed to take necessary action when informed of one or more incidents involving colleague A, in that you did not do all or some of the following:

a. Did not inform your regional manager, and/or Human Resources and/or the Care Quality Commission (CQC);

b. Did not investigate the incident and/or ensure appropriate corrective action taken;

c. Did not record the incident on DATIX;

d. Did not inform the Safeguarding Vulnerable Adults Department;

3. On 5 July 2016, failed to inform Safeguarding Vulnerable Adults Department of colleague A's suspension;

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

The original panel determined the following with regard to impairment:

> *"The panel was mindful that in deciding whether Mr Smyth's fitness to practise was impaired, it should ask itself whether he was liable to act in a similar way in future.*
>
> *The panel had received no evidence of remediation from Mr Smyth. In responding to the charges, he accepted that he had not kept proper records and was too trusting of colleagues. In the panel's view, Mr Smyth had clearly failed to understand the seriousness of his actions and where he went wrong. The panel's real concern was that he had failed to see "the bigger picture" and had not taken an overall view of the risk of employing Colleague A and the ongoing risk that this caused to residents.*
>
> *Mr Smyth had not at any time shown any remorse for his actions. Whilst he had accepted during the FSHC investigation that he had not always taken the required steps, the panel nonetheless found that his insight and understanding of where he went wrong was very limited.*
>
> *In assessing future risk, the panel also bore in mind that, when Mr Smyth was instructed by colleagues to contact the CQC and safeguarding and he still failed to do so and prioritised other matters. Ms 1 had told the panel that when she reported the incidents involving Colleague A to Mr Smyth, he did not seem interested. The panel also had regard to the email that Mr Smyth sent to his line manager following the incident which clearly failed to set out the full details of the incident. In the panel's view this greatly minimised the nature of the incident. These factors led the panel to conclude that Mr Smyth had failed to understand the gravity of the incident and such failure could enhance the risk of repetition.*
>
> *The panel was therefore satisfied that Mr Smyth was liable in future, to place patients at risk of harm, bring the profession into disrepute, and breach fundamental tenets of the profession. The panel had received no evidence to persuade it that the risk of repetition had been minimised at all. It was satisfied*

that the risk of repetition and consequently the risk to the public remained high and that a finding of impairment was necessary to protect the public."

The original panel determined the following with regard to sanction:

"The panel's view was that this case did not involve a single instance of misconduct. There was more than one incident of misconduct in that Mr Smyth failed to follow proper policies and procedures when employing Colleague A and subsequently failed to follow policies and procedures when incidents involving Colleague A were reported to him. The panel did not however find that there was evidence of a harmful deep-seated personality or attitudinal problem. … The panel also had not heard any evidence to suggest that there had been any repetition or similar behaviour since the incident. However, it bore it in mind, that Mr Smyth said in his written response that he was not currently working in nursing. The panel found that Mr Smyth only had limited insight into his misconduct and it was concerned about the risk of repetition, as set out on in the decision on impairment.

…

The panel found that Mr Smyth had committed a number of serious departures from the Code. Although he had not directly and personally caused harm to others, by employing Colleague A and not suspending him when he should have done so, his actions could have foreseeably resulted in harm to others.

Mr Smyth was in a position of trust although the panel had not been presented with any evidence which persuaded it that he had abused that position. As already outlined, it heard evidence that he had acted with good intentions. The panel also accepted that whilst Mr Smyth lacked insight into the seriousness of his actions and their consequences, it was not satisfied that this lack of insight was persistent. In particular, Mr Smyth had acknowledged some failings during the FSHC investigation and in his response to the NMC.

The panel was satisfied … that Mr Smyth's actions were not fundamentally incompatible with ongoing registration with the NMC. Its view was that whilst there are a number aggravating factors, there was mitigation which persuaded the panel that public confidence in the profession and the NMC would be sustained if Mr Smyth was not removed from the register. It concluded that a strike off would be inappropriate and disproportionate.

The panel therefore decided that an order of suspension is an appropriate and proportionate sanction. A suspension will prevent Mr Smyth from practising and consequently ensure that the public remains protected during the course of the suspension. It will also ensure that public confidence in the nursing profession is maintained, and proper standards of conduct and behaviour are upheld. An order of suspension also provides Mr Smyth with an opportunity to work towards a return to the nursing register at a later date should he choose to do so."

The previous review panel on 26 October 2018 determined the following with regard to impairment:

"Regarding insight, the panel carefully read Mr Smyth's statement dated 7 October 2018 prepared for the purposes of this hearing. The panel considered that this statement expresses remorse for his actions. However, it also considered Mr Smyth's statement to be self-centred. It does not demonstrate an understanding of how Mr Smyth's actions, through his poor management and hiring practices, indirectly put residents and his colleagues at an increased risk of harm. In addition, the panel considered that Mr Smyth's statement does not demonstrate an understanding of how his actions impacted negatively on the reputation of the nursing profession. Registered nurses are expected to display leadership responsibilities, especially with regard to safeguarding; Mr Smyth's statement does not address how his actions fell below the necessary standard, or how he would handle a similar situation differently in the future. For these reasons, the panel considered that Mr Smyth's insight is still developing.

The panel noted that no concerns have been raised about Mr Smyth's clinical practice, and that his misconduct related to poor managerial skills. However, Mr Smyth has not

provided any evidence of remediation (including, for example, online training on safeguarding or safe recruitment policies) or testimonials from his current employer. On this basis, the panel concluded that Mr Smyth has not evidenced full remediation of his misconduct."

The previous review panel on 26 October 2018 determined the following with regard to sanction:

"The panel considered imposing a further suspension order. It had regard to the SG and noted that the seriousness of the case, as well as Mr Smyth's lack of fully developed insight, requires his removal from the register, at least temporarily, and that a period of suspension would be sufficient to protect patients, public confidence in the nursing profession and professional standards. The panel has seen no evidence of any repetition on Mr Smyth's part, and he has engaged with the NMC's regulatory process to an extent.

The panel was of the view that a suspension order would allow Mr Smyth further time to more fully reflect on his previous failings. It considered that Mr Smyth needs to gain a full understanding of how his actions impacted upon patients, colleagues and the wider nursing profession.

In making this decision, the panel considered imposing a striking-off order. However, it concluded that such a sanction would be disproportionate in the circumstances. Although serious, Mr Smyth is engaging with this process and has developed his insight. The panel considered that he should be afforded a further opportunity to demonstrate remediation and evidence this before a reviewing panel.

[…]

This order will be reviewed before its expiry. A reviewing panel would be assisted by:

- *Mr Smyth's attendance, so as to demonstrate his level of insight;*

- *a further reflective statement detailing the impact of his actions on patients, colleagues and the reputation of the nursing profession, as well as setting out what he would do differently if placed in a similar situation in the future;*
- *evidence of any training (including online training) undertaken to keep up-to-date with the nursing profession; and*
- *testimonials from any current employers, irrespective of the type of work undertaken."*

Decision on current fitness to practise:

This panel has considered carefully whether Mr Smyth's fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's suitability to remain on the register without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. It has noted the decision of the previous panels. However, it has exercised its own judgment as to current impairment.

The panel heard the submissions of Mr Webb who explained the background to the case and guided the panel to the relevant elements of the previous panels' decisions with regard to misconduct, impairment and sanction. Mr Webb referred the panel to the recommendations made by the previous review hearing panel as to how Mr Smyth could assist a future reviewing panel. Mr Webb submitted that in light of his disengagement Mr Smyth has not responded to any of the recommendations and there was no new information which undermined a finding of current impairment. He therefore submitted that there remains a risk of repetition of the concerns identified in Mr Smyth's practice.

With regard to the question of sanction, Mr Webb referred the panel to the NMC's Sanctions Guidance (SG) and submitted that an order preventing Mr Smyth from unrestricted nursing practice remains necessary and the panel may take the view that a further period of suspension is appropriate.

The panel heard and accepted the advice of the legal assessor which included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)* in relation to the factors it should take into account when determining the question of impairment.

The panel considered whether Mr Smyth's fitness to practise remains impaired. In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel noted that the concerns identified in Mr Smyth's practice related to serious managerial failings which placed vulnerable residents at significant risk of harm. Whilst he had previously expressed an intention to return to nursing practice, the panel noted that Mr Smyth had not engaged with the NMC since October 2018. In light of Mr Smyth's disengagement the panel was unable to consider the issues of insight or any potential remediation. Mr Smyth has not responded to any of the recommendations of the previous review panel and there was no evidence that he had further reflected or developed insight or remediated his failings. The panel determined that there had been no material change in circumstances since the order was last reviewed. The panel therefore determined that, given the serious nature of the misconduct in this case, and the lack of remediation, there was a high risk of repetition and potential patient harm. The panel concluded that a finding of impairment remained necessary on the grounds of public protection.

The panel bore in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that a finding of impairment remained necessary on public interest grounds.

For these reasons, the panel finds that Mr Smyth's fitness to practise remains impaired.

Determination on sanction:

Having found Mr Smyth's fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 29 of the Order. The panel has also taken into account the NMC's SG and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the risk of repetition identified and the associated risk to patient safety. The panel then considered whether to impose a caution order but concluded that this would be inappropriate because a caution order would not provide the appropriate degree of protection to patients.

The panel considered whether a conditions of practice order would be appropriate. The panel had no information in relation to Mr Smyth's current personal or professional circumstances. The panel concluded that due to Mr Smyth's disengagement, it could not be satisfied that he would be willing to comply with conditions of practice.

The panel next considered a suspension order. The panel noted that Mr Smyth's has not taken the opportunity afforded to him in the past 6 months to provide evidence of further insight, training, reflection and remediation. The panel had no evidence that Mr Smyth has shown further insight and therefore determined that there is a significant risk of repetition. In these circumstances the panel concluded that a further period of suspension was no longer sufficient, appropriate or a proportionate sanction to protect the public or satisfy the public interest considerations of this case. In the panel's judgement, public confidence in the profession and the NMC as a regulator would be undermined by the imposition of a further period of suspension.

The panel next considered a striking off order. It concluded that Mr Smyth's failures were serious. His failings had placed residents at significant risk of harm. Mr Smyth has failed to take advantage of periods of suspension to reflect and demonstrate insight and remediation. His failures and ongoing lack of engagement raise fundamental questions about his professionalism. The panel determined that public confidence in the

profession could not be maintained if Mr Smyth was not removed from the register and that striking-off was now the only sanction which would be sufficient to protect patients, members of the public and maintain professional standards.

This order will take effect from the expiry of the current order on 22 May 2019.

This decision will be confirmed to Mr Smyth in writing.

That concludes this determination.