Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
4 - 5 April 2022

Virtual Meeting

Name of registrant:	Paul Michael Bright
NMC PIN:	93E0217E
Part(s) of the register:	Registered Nurse – Mental Health RN3: 2 June 1996
Area of registered address:	South Yorkshire
Type of case:	Misconduct
Panel members:	Rachel Childs (Chair, Lay member) Janet Richards (Registrant member) David Boyd (Lay member)
Legal Assessor:	Richard Tyson
Hearings Coordinator:	Jumu Ahmed
Facts proved by admission:	Charges 1, 2a, 2b, 2c, 3a, 3b, 4, 5, 6, 7, 8, 9, 10a, 10b, 11, 12a, 12b, 13
Facts not proved:	N/A
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that Mr Bright was not in attendance and that the Notice of Meeting had been sent to Mr Bright's registered email address on 6 January 2022.

Further, the panel noted that the Notice of Meeting was also sent to Mr Bright's representative at the Royal College of Nursing (RCN) on 6 January 2022.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and venue of the meeting.

In the light of all of the information available, the panel was satisfied that Mr Bright has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Decision and reasons for amending the charges

The panel, of its own volition, was of the view that amending charges 6, 7, 11 and 13 would provide clarity and more accurately reflect the evidence.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The NMC had notified the RCN of the proposed amendments and they had no objections to them.

The panel was of the view that such amendments were in the interests of justice. The panel was satisfied that there would be no prejudice to Mr Bright and no injustice would be caused to either party by the proposed amendments being made. It was therefore

appropriate to allow the amendments to ensure clarity and accuracy as the amendments were minor and largely typographical.

Original Charges

That you, a registered nurse, whilst working as a staff nurse for Linwood House:

6. On 27 February 2020, failed to review an unknown patient in a timely manner, having administered choldiazepoxide to them;

7. On 6 March 2020, recorded that you had administered two chlordiazepoxide 10mg tablets, when you had only administer one such tablet;

11. On 25 May 2020, failed to assess an unknown patient for alcohol dependency despite identifying that said patient had alcohol dependency and had previously suffered from seizures as a result;

13. Your conduct at charge 12.b. was dishonest in that you knew you had not carried out a sufficient review of the patient, but intended for anyone reading you reflective practice piece to believe that you had;

Proposed Charge

That you, a registered nurse, whilst working as a staff nurse for Linwood House:

6. On 27 February 2020, failed to review an unknown patient in a timely manner, having administered ~~choldiazepoxide~~ **chlordiazepoxide** to them;

7. On 6 March 2020, recorded that you had administered two chlordiazepoxide 10mg tablets, when you had only ~~administer~~ **administered** one such tablet;

11. On 25 May 2020, failed to assess an unknown patient for alcohol ~~dependency~~ **withdrawal** despite identifying that said patient had alcohol dependency and had previously suffered from seizures as a result;

12. …

13. Your conduct at charge 12.b. was dishonest in that you knew you had not carried out a sufficient review of the patient, but intended for anyone reading ~~you~~ **your** reflective practice piece to believe that you had;

Details of charge (as amended)

That you, a registered nurse, whilst working as a staff nurse for Linwood House:

1. On 24 June 2018, failed to record assessments for suicide attempts and drug allergies in Patient A's notes;

2. On 28 June 2018;

    a. Failed to observe Patient B hide their medication instead of taking it;
    b. Failed to support Colleague A (LW) when they confronted Patient B about hiding said medication;
    c. Administered 1g of Colchicine to Patient C, when the prescription was for 500mg;

3. On 29 June 2018;

    a. Allowed Colleague B (LT), a member of administrative staff, to drive Patient D to A&E when said patient showed signs of having suffered a stroke;
    b. Failed to provide Colleague B with any medical or identifying documents for Patient D;

And, whilst working as a custody nurse for CRG Forensic Medical Services;

4. On 2 December 2019, failed to refer an unknown head injury patient to hospital;

5. On 27 January 2020, failed to document your administration of 10mg of Diazepam to an unknown patient with a withdrawal score of 12;

6. On 27 February 2020, failed to review an unknown patient in a timely manner, having administered chlordiazepoxide to them;

7. On 6 March 2020, recorded that you had administered two chlordiazepoxide 10mg tablets, when you had only administered one such tablet;

8. On 22 April 2020, failed to refer an unknown patient to hospital after identifying Covid-19 concerns;

9. On 8 May 2020, failed to review an unknown patient in a timely manner after administering medication to them for alcohol withdrawal;

10. On 9 May 2020;

    a. Failed to escalate treatment and/or arrange for the monitoring of an unknown patient with a suspected head injury;
    b. Failed to properly assess an unknown patient with diabetes who had suffered a seizure in custody;

11. On 25 May 2020, failed to assess an unknown patient for alcohol withdrawal despite identifying that said patient had alcohol dependency and had previously suffered from seizures as a result;

12. On 2 June 2020;

a. Failed to carry out a 60-minute review on an unknown patient suffering from alcohol withdrawal;
b. Recorded in your reflective practice piece that you carried out a 60-minute review when you had not conducted a review on said patient;

13. Your conduct at charge 12.b. was dishonest in that you knew you had not carried out a sufficient review of the patient, but intended for anyone reading your reflective practice piece to believe that you had;

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

Background

Mr Bright was referred to the NMC on 26 October 2018 from Care Plus Group (the Group) in relation to a number of alleged failings in June 2018 in the areas of medication administration, care planning, risk assessment and record keeping. Mr Bright was working as a staff nurse for Linwood House (the House).

Mr Bright was first entered onto the NMC's register in July 1993 and became employed by the Group, as an existing member of staff at the House, when the Group took over the management of the House in April 2016. The House is a drug and alcohol rehabilitation centre.

On 24 June 2018, Mr Bright admitted Patient A to the House. He identified four different risk factors on their pre-admission assessment such as certain allergies and a previous suicide attempt. However, Mr Bright had failed to fully record these in Patient A's care plan.

It was further alleged by the Group that:

- On 28 June 2018, Mr Bright failed to follow local medication administration policy by not observing Patient B take their medication. The patient failed to take their medication and put it in their pocket, which over time, could lead to a serious health

risk. Mr Bright also failed to support a junior colleague when they challenged Patient B over the pocketing of their medication.

- Also on 28 June 2018, Mr Bright administered a dose of medication to Patient C which was double the prescribed dose. Patient C was meant to receive 500mg of Colchicine, however, 1g of Colchicine was administered.

- On 29 June 2018, Patient D was displaying signs of having a stroke. Mr Bright instructed a non-medically trained administrator to take Patient D to hospital in their own personal vehicle. This placed both the colleague and the patient at risk of harm. Mr Bright should have called an ambulance.

On 4 September 2018, a local disciplinary hearing was held, and Mr Bright was summarily dismissed.

Mr Bright commenced employment with CRG Forensic Medical Services ('CRG') on 5 November 2018 where he was working as a custody nurse at Lincoln Police Station in the Custody Suite ('the Suite').

The NMC received information from the CRG outlining concerns about Mr Bright's knowledge and skills in basic, fundamental areas of nursing practice including poor medication administration, record keeping, failing to carry out checks on patients and failing to identify or act on risks to patients. In light of these allegations a further risk assessment was carried out by the NMC on 16 June 2020.

It was alleged by CRG that:

- On 2 December 2019, Mr Bright failed to escalate a patient who had a severe head injury.

- On 27 January 2020, Mr Bright administered a patient 10g of diazepam against protocol and failed to document this properly.

- On 27 February 2020, Mr Bright failed to review a patient within the appropriate 60-

minute timeframe after administering their medication for alcohol withdrawal. He further failed to book their further reviews for later that evening.

On 28 February 2020 a decision was made by CRG that Mr Bright required a personal improvement plan ('PIP') to help address the areas of concern within his practice. This PIP was given to Mr Bright on 3 March 2020 for a period of 12 weeks. However, during these 12 weeks, a number of further concerns were raised.

- On 6 March 2020, Mr Bright recorded that he had administered two chlordiazepoxide 10mg tablets when he had only given one.

- On 22 April 2020, a patient was displaying symptoms of Covid-19 and Mr Bright failed to complete an assessment of them. This patient should have been assessed and transferred to hospital for the appropriate care.

- On 8 May 2020, Mr Bright failed to review a patient within the appropriate 60-minute timeframe and allowed them to sleep which was against policy and put the patient at risk of harm, as their withdrawal symptoms could be going undetected.

- On 9 May 2020, Mr Bright failed to escalate a serious head injury on a patient and failed to assess a diabetic patient who suffered a seizure in custody.

On 14 May 2020, due to the continuing concerns, the PIP was extended for a further two weeks.

- On 25 May 2020, Mr Bright again failed to assess a patient within the appropriate 60-minute timeframe following administration of their withdrawal medication.

On 2 June 2020, having again failed to carry out a 60-minute review with a patient suffering from alcohol withdrawal, Mr Bright was asked to submit a reflective piece as part of his PIP. This reflective piece contained facts which were not correct as it suggested that he had followed the correct procedure for a patient when contemporaneous patients note confirmed that he had not.

Decision and reasons on facts

At the outset of the meeting, the panel had regard to the completed Case Management Form (CMF) returned to the NMC by the RCN on behalf of Mr Bright. Within the CMF Mr Bright has made full admissions to charges 1, 2a, 2b, 2c, 3a, 3b, 4, 5, 6, 7, 8, 9, 10a, 10b, 11, 12a, 12b, and 13.

The panel therefore finds charges 1, 2a, 2b, 2c, 3a, 3b, 4, 5, 6, 7, 8, 9, 10a, 10b, 11, 12a, 12b, and 13 proved in their entirety, by way of Mr Bright's admissions.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Mr Bright's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mr Bright's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act

or omission which falls short of what would be proper in the circumstances.' The panel was mindful that in his judgment Lord Clyde emphasised that the misconduct must be serious.

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' ('the Code') in making its decision.

The NMC identified the specific, relevant standards where Mr Bright's actions amounted to misconduct.

The NMC's written representations on misconduct state:

> *'The misconduct was particularly serious in this case as it involved a vast number of errors over a prolonged period of time despite significant local support and intervention. Not only did these errors involve clinical failings in medication administration and record keeping, amongst other concerns, the Registrant provided a dishonest reflection following one such failure, and failed to support colleagues when necessary.*
>
> *The Registrant's actions gave rise to a significant risk of harm to patients in failing to administer correct medications, properly record medication and incidents, and in failing to adequately assess and care for patients, particularly vulnerable patients that required regular checks. The Registrant's failings would be viewed as deplorable by a fellow nurse, and accordingly, must constitute misconduct.'*

On impairment, the NMC submitted that the panel should bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel was referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Mr Bright's fitness to practise impaired. The NMC's written representations on impairment state:

'The NMC say that all four questions are answered in the affirmative in this case. The Registrant's failure to properly assess, treat, and escalate or record the patient care gave rise to a considerable unwarranted risk of harm. Further, this, coupled with his failure to support colleagues, clearly brings the profession into disrepute, and breaches fundamental tenets of the profession. Moreover, his reflective piece, deliberately suggesting that he had carried out a review he had not, is by definition, dishonest.

The Registrant has requested a meeting, made full admissions to all of the charges, and though it is of course, a matter for the panel, admitted that his fitness to practise is impaired as a result. Despite these admissions, he has failed to show any notable insight or remediation to address the significant concerns raised in this case. Accordingly, it is the NMC's submission that the Registrant poses a continuing risk to the public, and that a finding of impairment is thus necessary to protect the public.

Moreover, a finding of impairment in the public interest in this case is essential to declare and uphold proper standards of conduct and behaviour. The failures caused by the Registrant, both serious and numerous, bring the nursing profession into disrepute. The public rightly expect nurses to demonstrate the skills and knowledge fundamental to a nursing practice, ensuring that those standards are upheld and adhered to regardless of the challenge.'

The RCN, on behalf of Mr Bright, provided written representation on 21 March 2022. It made no specific submissions in relation to misconduct but stated:

'The registrant has indicated that he accepts all the charges and that his practice is currently impaired.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Nandi v General Medical Council [2004] EWHC 2317 (Admin)* and *General Medical Council v Meadow [2007] QB 462 (Admin)*.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mr Bright's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Bright's actions amounted to a breach of the Code. Specifically:

> ***'8 - Work co-operatively***
> *To achieve this, you must:*
>
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
>
> *8.2 maintain effective communication with colleagues*
>
> *8.5 work with colleagues to preserve the safety of those receiving care*
>
> ***10 - Keep clear and accurate records relevant to your practice***
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*
>
> *To achieve this, you must:*
>
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
>
> *10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

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 health and care setting and use the channels available to you in line with our guidance and your local working practices

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

19 - Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

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

20.2 act with honesty and integrity at all times …

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel bore in mind that nurses have a responsibility to provide safe and effective care to vulnerable patients. The panel determined that Mr Bright's failings and dishonesty amounted to misconduct.

The panel considered that Mr Bright's failings, which included dishonesty, demonstrated a significant departure from the standards expected of a registered nurse. The panel noted that there were significant number of errors over a lengthy period of time in two clinical settings. Mr Bright's clinical failings included: medication administration; record keeping, adequate assessment and care of patients, including vulnerable patients who required regular checks; and a dishonest reflection. Mr Bright had also failed to support junior colleagues on two separate occasions.

Mr Bright's misconduct, his failure to communicate with colleagues and work as a member of a team was serious and had caused a significant risk of harm to vulnerable patients under his care. Mr Bright had also caused a significant risk of harm to his colleague when he instructed Colleague B, a member of administrative staff, to drive Patient D to A&E when the patient showed signs of having suffered a stroke. The panel noted a pattern of behaviour whereby Mr Bright placed responsibilities that should have been his own upon the shoulders of others. For example, he told the Clinical Lead at CRG Medical that he needed her to "*keep at him"* in order to make sure he fulfilled the requirements of the role. The panel considered that this suggested a possible attitudinal issue that impacted on his ability to practise effectively.

The panel also noted that Mr Bright was supported in the two clinical settings and had a myriad of opportunities to recognise his failings in the Group and particularly in the Suite in the CRG. However, despite the number of opportunities given to Mr Bright, he had not changed his practice or learnt from his errors but had made more errors and acted dishonestly when completing his reflection. The panel was of the view that this further demonstrated that Mr Bright had an attitudinal issue.

The panel found that Mr Bright's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct. The panel was of the view

that Mr Bright's failings would be viewed as deplorable by fellow nurses, and accordingly, must constitute misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Bright's fitness to practise is currently impaired.

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.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution, or determination show that his/her fitness to practise is impaired in the sense that s/he:*

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel determined that all four limbs of the Grant test were engaged in this case.

The panel has found that vulnerable patients were at a real risk of harm as a result of Mr Bright's misconduct. Further, having found multiple breaches of the Code and dishonesty, the panel determined that Mr Bright's misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. All of these factors show why at the time of the charges Mr Bright was impaired. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find Mr Bright's failures and omissions to constitute impairment and the charges relating to dishonesty as serious.

Mr Bright made full admissions to the charges and admitted that his fitness to practice is impaired. The panel took into account Mr Bright's reflection to the NMC, which included personal and family issue and a health update. The reflection also stated:

'[PRIVATE].

I reiterate my utmost and heartfelt apology to the service users and to those colleagues at the time who were affected, I have never intentionally throughout my nursing career ever set out to cause any harm, upset, or detriment to any service user for whom I have a duty of care for, I personally endeavour to formulate a

relationship based on trust and candour, I always adhere to codes of practice as laid down by the NMC and keep myself up to date with self learning and employer provided courses.

[PRIVATE].

[PRIVATE].

The panel was of the view that Mr Bright's reflection demonstrated genuine remorse and a developing insight into the impact his actions could have had on patients and colleagues. However, it was of the view that it did not properly address any of the specific concerns identified in his practise, nor did it explore the reasons behind his dishonest reflective piece. Therefore, the panel could not be satisfied that Mr Bright fully understands and appreciates the seriousness of his dishonesty and failure to act appropriately.

The panel noted that Mr Bright has indicated that he does not intend to return to the nursing profession as he had applied for a Voluntary Removal (VR), which has been recently refused by the NMC.

In considering whether Mr Bright has strengthened his nursing practice, the panel noted that that it did not have any information before it to assess this. It noted that Mr Bright had not been practising as a registered nurse since 2019 and has not had the opportunity to demonstrate remediation. However, the panel was of the view that evidence of testimonials, supportive statements, Mr Bright's training record or CPD could have been provided as evidence to demonstrate that he is strengthening his practice. The panel was of the view that Mr Bright's misconduct is potentially remediable. However, it acknowledged that dishonesty and attitudinal issues are often more difficult to remediate than clinical concerns.

The panel noted that there were a significant number of errors over a lengthy period of time in two clinical settings. Mr Bright was supported by both of his employers and was provided the opportunity to strengthen his practice and learn from his errors. Mr Bright had the opportunity to learn from his mistakes he made in the House when he moved to the

CRG. However, he did not. In the absence of any evidence of remediation and a limited insight into his failings, the panel considered that there remains a risk of repetition of Mr Bright's failings and dishonesty and, therefore, a risk of unwarranted harm to patients in his care, should adequate safeguards not be imposed on his nursing practice. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel considered there to be a public interest in the circumstances of this case. The panel found that the charges found proved are serious and include dishonesty. It was of the view that a fully informed member of the public would be concerned by its findings on facts and misconduct. The panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Mr Bright's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of six months. The effect of this order is that the NMC register will show that Mr Bright's registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in the Notice of Meeting, dated 19 January 2022, the NMC had advised Mr Bright that it would seek the imposition of a suspension order for a period of six months if it found Mr Bright's fitness to practise currently impaired.

The panel also bore in mind the RCN's written representation on 21 March 2022:

> *'We request the panel consider making a finding of impairment but issuing no order and allow the registrant's pin to lapse. This would bring proceedings to a close, prevent the costly and resource consuming work entailed in prolonging such proceedings and would mark the wrongdoing thus serving the public interest. The public risk would be reduced by his pin having lapsed, any attempts to re-join the register would be protected by the outcome of the hearing and evidence of his declaration, all available to the registrar.*
>
> *[…]*
>
> *If the panel is not minded to consider a natural lapse we merely suggest that a conditions of practice order would seem inappropriate given the circumstances and consideration should always be given to whether the charges reach the threshold of a striking off order.'*

Decision and reasons on sanction

Having found Mr Bright's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- A pattern of misconduct over a period of time while employed consecutively at two organisations.
- Conduct which put vulnerable patients at significant risk of suffering harm.
- Failure to remediate or attempt to remediate despite being given significant support within the workplace.

The panel also took into account the following mitigating features:

- Comprehensive admissions to the charges.
- Some insight into his misconduct.
- Genuine remorse.
- Personal mitigation including family and personal issues.

The panel considered the NMC's guidance on dishonesty. In light of the circumstances, the panel determined that Mr Bright's dishonest conduct was at the lower end of the spectrum as it was a single incident of dishonesty and could be described as opportunistic.

The panel first considered whether to take no action.

The panel took into account the RCN's written representation on 21 March 2022:

> *'*[PRIVATE].
> *[…] The registrant is no longer working in healthcare and has communicated that he has no desire to return to nursing practice, his renewal is due in June 2022.'*

The panel considered the representations from the RCN which had requested that no order be made, and Mr Bright's PIN be allowed to lapse. However, it considered that this would not adequately uphold proper professional standards. Further, the panel had no way of guaranteeing that Mr Bright would not return to practice if an order was not made and considered that such a course of action would not adequately protect the public.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Bright's practice would not be appropriate in the circumstances. The SG states

that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Bright's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Bright's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable, and workable.

The panel is of the view that there are no practical or workable conditions that could be formulated at this stage, given the nature of the findings and all the circumstances in this case. The panel noted that Mr Bright had some developing insight into his misconduct but was of the view that this was not sufficient. There was no evidence of any remediation by Mr Bright. The panel determined that Mr Bright was an experienced nurse and that his misconduct breached basic fundamental tenets of the nursing profession. While in theory Mr Bright's misconduct involved, in the main, areas of professional practice that could be addressed with conditions, he had not demonstrated that he was able to respond positively to retraining or supervision. Mr Bright had previously been given two opportunities to respond to the support he was given by his employers. However, at both the CRG and the House, he did not respond effectively or show a willingness to respond. Further, Mr Bright's misconduct included dishonest conduct which would be difficult to remediate. Therefore, the panel concluded that the placing of conditions on Mr Bright's registration would not adequately address the seriousness of this case. A conditions of practice order would not protect the public, nor would it satisfy the public interest considerations.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- The seriousness of the misconduct requires a temporary removal from the NMC Register.

The panel considered whether the seriousness of this case could be addressed by temporary removal from the register and whether a period of suspension would be sufficient to protect patients and satisfy the wider public interest concerns. When considering seriousness, the panel took into account the extent of the departure from the standards to be expected of a registered nurse and the risk of harm to the public interest caused by that departure. It had already concluded that the level of dishonest conduct was at the lower end of the spectrum in that it was a one-off incident which appeared to be spontaneous. The panel, therefore, considered that the public interest considerations can be satisfied by a less severe outcome than permanent removal from the NMC register while at the same time sending to the public and the profession a clear message about the standard of behaviour required of a registered nurse. The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr Bright's case to impose a striking-off order. The panel decided that Mr Bright should be afforded the opportunity to demonstrate insight, remorse, and remediation into his misconduct. Therefore, the panel concluded that a striking-off order was not necessary in Mr Bright's case, at this stage.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction and would mark the seriousness of the misconduct. The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of six months was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Mr Bright's full engagement with the NMC in the future;
- Attendance at any future hearing;
- A clear statement on whether Mr Bright has renewed his PIN registration, or whether it had lapsed in June 2022;
- A clear statement from Mr Bright's about whether he intends to return to the nursing profession or otherwise.

If Mr Bright does intend to return to the nursing profession a reviewing panel would be assisted by:

- Evidence of a reflective piece;
- Evidence of CPD;
- Evidence of any up-to-date training, specifically addressing the concerns in this case;
- Evidence of relevant testimonial and/or character testimonials from Mr Bright's current employer, whether in paid or unpaid employment. This must have particular regard to his failings found proved.

This will be confirmed to Mr Bright in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Bright's own interest until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC:

> *'If a finding is made that the registrant's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed, it is the NMC's submission that an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.'*

Decision and reasons on interim order

The panel heard and accepted the advice of the Legal Assessor.

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months due to cover the 28-day appeal period and any period of appeal.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Mr Bright is sent the decision of this hearing in writing.

That concludes this determination.