Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 25 July – Tuesday 2 August 2022

Virtual Hearing

Name of registrant:	**James Turner Kerr**
NMC PIN:	03I1541S
Part(s) of the register:	Registered Nurse – RNMH Mental Health Nursing – September 2006
Relevant Location:	West Lothian
Type of case:	Misconduct
Panel members:	Michael Murphy (Chair, Registrant member) Lisa Punter (Registrant member) Chris Thornton (Lay member)
Legal Assessor:	Mark Ruffell
Hearings Coordinator:	Khadija Patwary
Nursing and Midwifery Council:	Represented by Dominic Bardill, Case Presenter
Mr Kerr:	Present (during Fact Finding Stage) Not present (during Misconduct/Impairment and Sanction Stages) and represented by Adam Black, instructed by Anderson Strathern
Facts proved:	Charges 2 and 3
Facts not proved:	Charge 1
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Details of charge

That you, a registered nurse:

Patient C

1. On unknown dates between early 2017 and 2020: **(not proved in its entirety)**
    a) Pushed patient C.
    b) Failed to assist patient C off the floor.
    c) Said to patient C the words in schedule A.
    d) Said to patient C the words in schedule B.
    e) Said to patient C the words in schedule C.
    f) Said to patient C the words in schedule D.

Patient D

2. On or around 20 August 2017: **(proved in its entirety)**
    a) Shouted to patient D the words in schedule E.
    b) Shouted at patient D the words in schedule F.
    c) Pushed patient D.

Patient A

3. On or around 4 March 2018:
    a) Forcefully dragged patient A. **(proved)**
    b) Failed to document a full account of the incident described at ‘a)’ above. **(proved)**
    c) Failed to complete a Datix for the incident described at ‘a)’ above. **(proved by admission)**

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

Separate Schedules

Schedule A: “you’ll be more comfortable down there” or words to this effect.
Schedule B: “now try to get up” or words to this effect.
Schedule C: “I’ve seen you without your clothes on” or words to this effect.
Schedule D: “well, you won’t have any next time” or words to this effect.
Schedule E: “I am not your husband” or words to this effect.
Schedule F: “go away” or words to this effect.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Bardill, on behalf of the NMC, to amend the wording of charge 3)a).

The proposed amendment was to remove the words “*by the wrists into her room*” in charge 3)a). Mr Bardill submitted that the essence of the offence was the words “*forcefully dragged Patient A*” and the remaining words were superfluous. He proposed removing the words *by the wrists into her room.*” He submitted that amending this charge will not prejudice you. Mr Bardill submitted that the proposed amendment would provide clarity and more accurately reflect the evidence.

“That you, a registered nurse:

Patient C

1. *On unknown dates between early 2017 and 2020:*
   a) *Pushed patient C.*
   b) *Failed to assist patient C off the floor.*
   c) *Said to patient C the words in schedule A.*

d) Said to patient C the words in schedule B.

e) Said to patient C the words in schedule C.

f) Said to patient C the words in schedule D.

Patient D

2. On or around 20 August 2017:

a) Shouted to patient D the words in schedule E.

b) Shouted at patient D the words in schedule F.

c) Pushed patient D.

Patient A

3. On or around 4 March 2018:

a) Forcefully dragged patient A ~~by the wrists into her room~~.

b) Failed to document a full account of the incident described at 'a)' above.

c) Failed to complete a Datix for the incident described at 'a)' above.

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

The panel heard from submissions from Mr Black that he does not oppose the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on application for hearing to be held in private

Mr Bardill, on behalf of the NMC, made a request that parts of the hearing be held in private on the basis that there are references to Witness 3's personal circumstances and health. The application was made pursuant to Rule 19 of the Rules.

Mr Black, on your behalf, indicated that he supported the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that there will be references to Witness 3's personal circumstances and health, the panel determined to hold parts of the hearing in private in order to preserve the confidential nature of those matters. The panel is satisfied that these considerations justify that course, and that this outweighs any prejudice to the general principle of hearings being in public.

Decision and reasons on application to allow Mr Kerr to dial into the hearing whilst Witness 3 is giving evidence

The panel heard an application made by Mr Bardill to allow Mr Kerr to dial into the hearing only for the duration of Witness 3's evidence as she had expressed [PRIVATE]. [PRIVATE]. Mr Bardill submitted that Witness 3's concerns are not in relation to the charges directly.

Mr Black submitted that he does not oppose the application.

The panel heard and accepted the legal assessor's advice on the issues and in particular that it should not hold the need for this application against you.

The panel gave the application in regard to Witness 3 serious consideration. In these circumstances, the panel came to the view that it would be fair and relevant to allow Mr Kerr to dial into the hearing whilst Witness 3 is giving evidence to ensure that Witness 3 can give her best evidence. The panel noted that there is no suggestion that your behaviour was inappropriate and that no inference would be drawn by the panel in granting this application.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Mr Black on your behalf, who informed the panel that you admitted charge 3)c).

The panel therefore finds charge 3)c) proved, by way of your admission.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Bardill on behalf of the NMC and by Mr Black on your behalf.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Patient C: Patient at the Hospital at the time of the incidents
- Witness 2: Community Psychiatric Nurse Team Leader at the Hospital at the time of the incidents
- Witness 3: Nursing Assistant at the Hospital at the time of the incidents
- Witness 4: Band 2 Healthcare Assistant at the Hospital at the time of the incidents

- Witness 5: Band 5 Registered Nurse at the Hospital at the time of the incidents

- Witness 6: Acting Charge Nurse at the Hospital at the time of the incidents

The panel also heard evidence from you under oath. The panel gave weight to your good character when considering the evidence that you gave.

Background

The charges arose whilst you were employed as a registered mental health nurse by NHS Lothian (the Hospital) It is alleged that Patient C had raised concerns with an Occupational Therapy (OT) support worker, that during one of their admissions to the Ward you had pushed them so that they fell on the floor. You did not assist Patient C to get up from the floor. As a result of this matter a former Team Leader, interviewed Patient C along with the OT Manager on 9 August 2019. Patient C described the events in question but was unable to remember the exact date, which they attributed to their health condition.

It is also alleged that on 20 August 2017, Patient D was trying to take paper towels away from another patient who had put them on their chest while eating. You tried to direct Patient D away several times and then began to raise your voice telling Patient D to "*get out"* of the room. Witness 3 was in the nurse's office and heard you shouting, and you were saying *"I am not your husband."* Witness 4 then stated that she saw you pushing Patient D out of the room, and then Patient D stumbled. Witness 3 then came out of the office and saw Patient D stumbling and observed that their slippers had come off. Witness 3 did not know why Patient D had stumbled but heard you say, "*go away."* [PRIVATE].

On 4 March 2018, Patient A had become [PRIVATE]. Patient A did not appear to want to go to her room and threw herself on the floor outside of her room. It is alleged that you then dragged Patient A along the floor. It is also alleged that you failed to document this incident adequately in Patient A's notes and that you failed to complete the required Datix incident form.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Mr Black on your behalf.

The panel then considered each of the disputed charges and made the following findings.

Charge 1)a)

1. On unknown dates between early 2017 and 2020:
    a) Pushed patient C.

This charge is found NOT proved.

In reaching this decision, the panel took into account Patient C's and your oral evidence.

The panel noted that Patient C in her oral evidence was consistent in her account that an incident did occur while you were alone with Patient C in the quiet sitting room. However, the panel also noted that Patient C had said in an interview nearer the time of the alleged incident that she was in a room with other patients and staff at the material time. The panel heard evidence that there were no other witnesses present. The panel considered that the events described by Patient C were in themselves inherently unlikely to have occurred. The panel determined that in the absence of any corroborative evidence, it could not be satisfied on the balance of probabilities that the account given by Patient C was credible.

In light of the above, the panel therefore finds charge 1)a) not proved.

Charge 1)b)

1. On unknown dates between early 2017 and 2020:
   b) Failed to assist patient C off the floor.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence considered from charge 1)a). The panel found charge 1)a) not proved and it was not satisfied on the balance of probabilities that you pushed Patient C to the floor. There is no other evidence to suggest that Patient C was on the floor in any capacity requiring assistance from you.

In light of the above, the panel therefore finds charge 1)b) not proved.

Charge 1)c)

1. On unknown dates between early 2017 and 2020:
   c) Said to patient C the words in schedule A.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence considered from charge 1)a) and 1)b). The panel found charge 1)a) and 1)b) not proved. It determined that you did not push Patient C and it follows accordingly that you did not say "*you'll be more comfortable down there*" or words to this effect.

In light of the above, the panel therefore finds charge 1)c) not proved.

Charge 1)d)

1. On unknown dates between early 2017 and 2020:
    d) Said to patient C the words in schedule B.

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence considered from charge 1)a) and 1)b). The panel found charge 1)a) and 1)b) not proved. It determined that you did not push Patient C and it follows accordingly that you did not say "*now try to get up*" or words to this effect.

In light of the above, the panel therefore finds charge 1)d) not proved.

Charge 1)e)

1. On unknown dates between early 2017 and 2020:
    e) Said to patient C the words in schedule C.

This charge is found NOT proved.

The panel considered the reliability of Patient C's evidence in relation to this sub charge. It further considered the likelihood of you making such comments in the context of admitting Patient C to the ward and in the absence of any corroborative evidence. Accordingly, the panel was not satisfied, on the balance of probabilities, that you did say "*I've seen you without your clothes on*" or words to this effect.

In light of the above, the panel therefore finds charge 1)e) not proved.

Charge 1)f)

1. On unknown dates between early 2017 and 2020:
    f) Said to patient C the words in schedule D.

This charge is found NOT proved.

The panel considered the reliability of Patient C's evidence in relation to this sub charge. It further considered the likelihood of you making such comments in the context of a chance meeting with Patient C in the Livingston Centre. The panel preferred your evidence in relation to this charge and accordingly it was not satisfied, on the balance of probabilities, that you did say "*well, you won't have any next time*" or words to this effect.

In light of the above, the panel therefore finds charge 1)f) not proved.

Charge 2)a)

2. On or around 20 August 2017:
    a) Shouted to patient D the words in schedule E.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3, 4 and 5's oral evidence.

Witness 3 in her oral evidence had told the panel that she heard you say "*I am not your husband*" to Patient D. Witness 5 also told the panel that after the incident Patient D had informed Witness 5 that she thought you were her husband. The panel determined that Witness 3, 4 and 5 were all consistent in their oral evidence in so far as they all said they heard you shouting.

The panel was satisfied, on the balance of probabilities, that you shouted at Patient D "*I am not your husband*" or words to this effect.

In light of the above, the panel therefore finds charge 2)a) proved.

Charge 2)b)

2. On or around 20 August 2017:
   b) Shouted at patient D the words in schedule F.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3 and 5's oral evidence and your oral evidence.

The panel noted that although Witness 4 had said that there was shouting, she was unable to recall what you had shouted at Patient D. Witness 3 in her oral evidence told the panel that she heard you shouting at Patient D "*go away*" and Witness 5 said that she heard you shouting the words "*get out*" to Patient D which the panel determined are words to the effect of "*go away*". You told the panel that you had made several failed attempts to remove Patient D from the room as you were wary of another patient engaging with Patient D and were concerned for Patient D's safety.

The panel was satisfied, on the balance of probabilities, that you shouted at Patient D the words "*go away*" or words to that effect.

In light of the above, the panel therefore finds charge 2)b) proved.

Charge 2)c)

2. On or around 20 August 2017:
    c) Pushed patient D.

This charge is found proved.

In reaching this decision, the panel took into account your evidence and that of Witnesses 3, 4 and 5.

The panel noted that Witnesses 3, 4 and 5 all viewed the impact of the alleged push from behind albeit from different angles. Witness 5 told the panel that she did not have a clear view of Patient D's back as they were facing Witness 5, but she stated that she saw you using some force. Witness 4 described you as using a significant level of force while your hand was on Patient D. Witness 3 said that she did not see the push however, Witnesses 3, 4 and 5 all say that they saw Patient D stumbling.

In your oral evidence, you said you were guiding Patient D and that she stumbled because of her loose-fitting slippers.

The panel was satisfied it was more likely than not that you pushed Patient D. In coming to its decision, the panel considered the word *"pushed"* in the sub charge to mean the applying of inappropriate force in the circumstances. The panel did not consider that you intended to harm Patient D.

In light of the above, the panel therefore finds charge 2)c) proved.

Charge 3)a)

3. On or around 4 March 2018:
    a) Forcefully dragged patient A.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's evidence and your oral evidence.

Witness 3 in her oral evidence told the panel that she saw you drag Patient A by her wrists whilst Patient A laid on the floor. Witness 3 described how that caused Patient A's loose-fitting top to ride up exposing her breasts. In your oral evidence, you said that you had initially moved quickly to restrain Patient A as she began to run in the direction of the tea trolley. Patient A then slid from your grip and onto the floor causing her top to ride up and her breasts to be exposed. You then described how you quickly pulled Patient A a short distance backwards into her room with your hands under her armpits and that you did so to preserve her dignity. It was your evidence that this was the most appropriate thing to do.

The panel determined that regardless of purpose or motivation you forcefully dragged Patient A. The panel considered that there were other alternative strategies to manage the situation. Both your evidence and that of Witness 3 describe you as standing behind Patient A and, using your hands, causing her to move across the floor albeit a short distance. The handling of Patient A in this way was contrary to the Hospital's moving and handling and restraint policies.

In light of the above, the panel therefore finds charge 3)a) proved.

Charge 3)b)

3. On or around 4 March 2018:
    b) Failed to document a full account of the incident described at ‘a)’ above.

This charge is found proved.

In reaching this decision, the panel took into account your oral evidence, the evidence of Witness 6 and Patient A’s Patient Progress/Communication Sheet dated 3 March 2018.

In your oral evidence, you told the panel that the primary purpose of a patient’s notes is to document what was relevant and needed for the next shift. Patient A’s notes contained no reference to the incident described in relation to charge 3)a) above. You later conceded that the omissions in the patient’s documentation were an oversight.

The panel considered carefully the evidence of Witness 6 and determined that the details of the incident and the impact on Patient A were significant and worthy of being documented in Patient A’s notes. Witness 6 told the panel that as a registered nurse you had a duty to document the incident or ensure it was documented. The panel determined that the evidence you provided in Patient A’s Progress/Communication Sheet was not a documented full account of the incident that had occurred. The panel did not accept your evidence in this regard, and it was the panel’s view that by failing to document the incident you were attempting to downplay it.

In light of the above, the panel therefore finds charge 3)b) proved.

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 your 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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Bardill provided written submissions and amplified them orally to the panel.

Mr Bardill submitted that your actions, in the context of the charges found proved (both by admission and on the facts), amount to misconduct. He referred the panel to the NMC Guidance on 'Seriousness' in particular those sections titled: 'Serious concerns which could result in harm to patients if not put right' and 'Serious concerns based on public confidence or professional standards.'

Mr Bardill invited the panel to consider any attitudinal issues as well as potential harm to patients and the risk of repetition. He submitted that the facts found proved consisted of both actions and omissions and that as a result patients were placed at real risk of harm.

Mr Bardill further submitted that omitting to keep proper records in respect of the incident with Patient A creates a further risk of harm to the public, by creating issues for fellow members of staff (i.e., the risk of making clinical errors, the risk of not providing care under the belief it had been rendered, etc.). He submitted that other members of staff are considered part of the public in respect of assessing the risk to safety and the risk of repetition.

Mr Bardill invited the panel to consider that notwithstanding the admission to Charge 3)c) at the outset, during proceedings you demonstrated no insight whatsoever and that at times you were combative in your answers. He submitted that whilst you admitted that the methods you used, namely with Patient A, were not in any of the handbook or policy documents you nonetheless refused to accept any alternative way of dealing with the situations presented to you. You furthermore sought to attach malicious intentions to other staff members of staff who had raised their concerns and given evidence.

Mr Bardill submitted that you have practised as a registered nurse for around 18 years with no NMC findings against your name.

Mr Bardill invited the panel to take the view that your actions and omissions amount to a breach of 'The Code: Professional standards of practice and behaviour for nurses and midwives' (2015) ("the Code"). He then directed the panel to specific paragraphs and standards and identified where, in the NMC's view, your actions amounted to a breach of those standards.

Mr Black, on your behalf, submitted that you admit misconduct.

Submissions on impairment

Mr Bardill moved on to the issue of impairment and addressed the panel on the need to have regard to 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.

Mr Bardill submitted that without remediation there remains a real risk to patient safety and of repetition in a case where the behaviour appears to have already been repeated. He submitted that, consequently, the risk to patient safety and of repetition, is clear and ongoing. Mr Bardill urged a finding of current impairment on public protection grounds.

Further, Mr Bardill invited the panel to consider a finding of impairment on public interest grounds. He submitted this was necessary in order to maintain public trust and confidence in the profession, and to fulfil one of the panel's duties of declaring and upholding proper standards of professional conduct.

Mr Black, on your behalf, submitted that you admit impairment.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (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.'*

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.3*** *avoid making assumptions and recognise diversity and individual choice*
> ***1.4*** *make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***8 Work cooperatively***
> *To achieve this, you must:*
> ***8.2*** *maintain effective communication with colleagues*
> ***8.3*** *keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*
> ***8.5*** *work with colleagues to preserve the safety of those receiving care*
> ***8.6*** *share information to identify and reduce risk*

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 all 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*

10.3 *complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.4 *take account of your own personal safety as well as the safety of people in your care*

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.2 *explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers*

14.3 *document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly*

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, treating people fairly and without discrimination, bullying or harassment'*

The panel acknowledge that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each of the charges individually.

In relation to charge 2, the panel considered charge 2)a) and 2)b) and were of the view that, on their own, your actions in respect of these charges did not amount to misconduct. However, the form of words used (or words to their effect), were unnecessary, unprofessional and potentially hurtful to Patient D.

In respect of charge 2)c) the panel was of the view that whilst there was no evidence of Patient D being in immediate danger, pushing Patient D (irrespective of the amount of force used) [PRIVATE]. The panel further noted that Patient D was a particularly [PRIVATE]. Your behaviour in relation to charge 2)c) would by the standards of ordinary people, and fellow professional nurses, be judged to be deplorable falling far below the expected standards of a registered nurse. The panel considered that your actions in 2)a) and 2)b) increased the seriousness of the misconduct found in 2)c).

In respect of charge 3)a), the panel were of the view that your actions were particularly serious. The forceful dragging of Patient A [PRIVATE], was a serious departure from your responsibilities as a registered nurse.

In respect of charge 3)b), your failure to document a full account of the incident described in charge 3)a) resulted in you not identifying the risks or problems the incident presented. By not describing the steps taken to manage the incident, you failed to make an accurate record of the incident and provide colleagues using the records with all the relevant information regarding Patient A's progress. This was a serious departure from your responsibilities as a registered nurse.

Your behaviour in relation to charges 3)a) and 3)b) would by the standards of ordinary people, and fellow professional nurses, be judged to be deplorable falling far below the expected standards of a registered nurse.

In respect of charge 3)c), a charge you admitted at the outset of the hearing, the panel was of the view that despite it being your duty to complete a Datix for the incident in charge 3)a), your failure to do so did not in itself amount to misconduct. Whilst you admitted this charge in the course of your oral evidence, you dismissively stated that it was either an oversight or you were too busy to complete it. The panel considered that your actions in 3)c) increased the seriousness of the misconduct found in 3)a) and 3)b).

The panel found that your actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your 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. 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) *...'*

The panel finds that patients were put at risk and were caused risk of physical and emotional harm as a result of your misconduct. Your misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It went on to consider whether there may be a risk of repetition and in doing so it assessed your current insight, remorse and remediation.

Whilst the panel is of the view that your conduct may be remediable it has not been provided with any evidence of insight, reflection or remorse from you. You have provided no evidence of how you propose to strengthen your nursing practice. Throughout your oral evidence at the facts stage you adamantly refuted you had done anything wrong. The panel concluded that there is a high risk of your behaviour being repeated, putting patients at future risk of harm, bringing the nursing profession into disrepute and breaching the fundamental tenants of the profession.

The panel concluded 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; 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. This 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 concluded that public confidence in the profession would be undermined if a finding of current impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that your fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike you off the register. The effect of this order is that the NMC register will show that you have been struck-off the register.

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.

Submissions on sanction

Mr Bardill provided written submissions and amplified them orally to the panel.

Mr Bardill provided the panel with a list of aggravating features:

- A lack of insight into the failings identified;
- A lack of candour;
- Putting vulnerable patients at risk of suffering harm; and
- Engaging in a pattern of misconduct over time.

Mr Bardill also provided the panel with mitigating features:

- You admitted to charge 3)c) from the outset;
- There are no previous sanctions or NMC findings so therefore you have a relatively long history of unblemished service;
- You have since admitted and accepted misconduct and impairment albeit after the factual stage; and
- That at the material time you were [PRIVATE] in the workplace having only meant to be there for a much shorter period.

Mr Bardill submitted that these are not exhaustive, and the panel may find additional aggravating and mitigating features to which they will attach the appropriate weight accordingly.

Mr Bardill submitted that in your case a caution order would not be sufficient to reflect the seriousness of the case or to protect the public. He submitted that a conditions of practice order would not be appropriate to address the lack of insight and candour, and therefore would not protect the public. Mr Bardill submitted that some of your behaviour did take place in full view of patients, staff and visitors which suggests that any supervision or conditions of that nature would be ineffective. Mr Bardill further submitted that a suspension order is not the appropriate sanction because it would not address insight or remediation and the consequent longer-term risk.

Mr Bardill submitted that the public protection and public interest concerns were so serious that the only appropriate sanction to protect the public and uphold the reputation of the profession and the NMC as a regulator is a strike off order.

Mr Black submitted that the mitigating factors in your case were that you had no previous regulatory findings, that you admitted charge 3)c) at the outset, that the incidents occurred at a [PRIVATE] period of time in your practice and that you did not intend to harm either patient.

Mr Black submitted that no further action and a caution order would be an inappropriate sanctions in this case. He submitted that the panel should impose a conditions of practice order which will be a sufficient and proportionate response to protecting the public and the wider public interest. Mr Black submitted that there is limited evidence to suggest that you have a harmful deep-seated personality and attitudinal problems.

Mr Black submitted that conditions can be formulated to address the identifiable areas of concern in your practice. Conditions can include reassessment or training, manual handling and restraint and record keeping. He submitted that a conditions of practice order will protect patients whilst incorporating supervision. Mr Black submitted that a more serious sanction would be disproportionate and that the panel should bear in mind that you have been practising for a lengthy period of time without any issues. Mr Black submitted that the conditions of practice order should be for 12 months as you are currently not in a nursing role, and this will allow you to find work.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found your 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 considered the following were aggravating features:

- Lack of candour in relation to record keeping
- It is not a single incident and both incidents involve similar themes of patients being inappropriately restrained and manually handled
- Lack of insight
- Trying to displace blame onto others by stating they are professionally jealous of you
- Risk of harm to vulnerable patients

The panel considered the following were mitigating features:

- Admitted charge 3)c) from the outset of the hearing
- Admitted to misconduct and impairment albeit after the factual stage

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would not be adequate to protect the public or otherwise be in the public interest to take no further action.

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 your 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 your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. 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 your registration would be a sufficient and appropriate sanction. The panel is mindful that any conditions imposed must be relevant, proportionate, measurable and workable. Your lack of insight or reflection and remediation lead the panel to conclude that the risk of repetition is high and that there are no practical or workable conditions that could be formulated to address the identified concerns. The panel concluded that there is no information before it as to whether you are willing to comply with any conditions, given your lack of engagement at this stage. The panel therefore concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not protect the public and public interest concerns.

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:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel was of the view that this was not a single instance of misconduct and that you have failed to demonstrate any insight into your failings and as a consequence there remains a significant risk that you may repeat the behaviour.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse with serious breaches of the Code. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction. While a suspension order may protect the public it will not uphold the wider public interest.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel was of the view that there was a total lack of evidence of insight, remorse, reflection or any efforts to demonstrate that you have strengthened your nursing practice. Your actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your actions were serious and to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of your actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct yourself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was 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.

Interim order

As the striking-off 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 your own interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel considered the submissions made by Mr Bardill that an interim suspension order should be made to cover the appeal period. He submitted that an interim order is necessary to protect the public interest. He invited the panel to impose an interim suspension order for a period of 18 months to cover the appeal period and any appeal if made.

Mr Black, on your behalf submitted that it is matter for the panel.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim suspension order is necessary to protect the public interest. The panel had regard to the seriousness of the misconduct and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. It considered that to not impose an interim suspension order would be inconsistent with its earlier findings.

Therefore, the panel made an interim suspension order for a period of 18 months.

If no appeal is made, then the interim suspension order will be replaced by the striking-off order 28 days after you are sent the decision of this hearing in writing.

This will be confirmed to you in writing.

That concludes this determination.