Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 12 December 2022

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

Tuesday 13 – Thursday 16 December 2022

Monday 19 – Wednesday 21 December 2022

Virtual Hearing

Name of Registrant:	**Simon John Wright**
NMC PIN	04L0316E
Part(s) of the register:	Registered Mental Health Nurse (April 2005)
Relevant Location:	Warrington
Type of case:	Misconduct
Panel members:	Anne Ng (Chair, lay member) Jonathan Coombes (Registrant member) Caroline Friendship (Lay member)
Legal Assessor:	John Donnelly
Hearings Coordinator:	Alice Byron (12 – 16 and 20 -21 December 2022) Chandika Cheekhoory-Hughes-Jones (19 December 2022)
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter
Mr Wright:	Not Present and unrepresented
Facts proved:	Charges 1a, 1b, 1c, 1d, 1e, 2a, 3a, 3b, 3c, 4, 5, 6a, 6b, 7, 8 and 9

Facts not proved:	Charges 1f and 2b
Fitness to practise:	Impaired by reason of misconduct
Sanction:	**Striking off order**
Interim order:	**Interim Suspension Order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Wright was not in attendance and that the Notice of Hearing letter had been sent to Mr Wright's registered email address by secure email on 9 November 2022.

Mr Edwards, on behalf of the Nursing and Midwifery Council (NMC), submitted that it 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).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing, information about Mr Wright's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

The panel had regard to the email sent to Mr Wright by the Listings Team at the NMC, dated 9 November 2021, which attached a link to the notice of hearing. It was satisfied that the Notice of Hearing contained the correct details for this hearing, however the email was entitled: *"Notice of Virtual hearing"* and erroneously set out: *"Your Substantive Hearing is due to take place on 21 December 2022".* Mr Edwards submitted that, despite this error, proper service could be found in line with the Rules. Further, the panel was informed that the Hearings Coordinator had immediately prior to the hearing telephoned Mr Wright and left a voicemail with contact details. This was followed up by an email with the hearing details, including the option to attend virtually.

The panel had concerns as to whether service had been effected in line with the Rules. It noted that the Witness Statement of the NMC Listing Officer, exhibiting the Notice of Hearing and the email in which it was sent, was unsigned and undated. The panel could not be satisfied that Mr Wright had opened the link containing the Notice of Hearing, and

therefore may have been unintentionally misled into believing that this hearing was due to commence on 21 December 2022.

Mr Edwards invited the panel to consider an email, dated 16 November 2022, from a Listing Officer at the NMC, which corrected the email dated 9 November 2022, which set out:

> *"I am sending you this email, further to my last email to inform you that your Substantive Hearing is due to take place on 12 December 2022 to 21 December 2022".*

The panel was satisfied that this email sufficiently corrected the error contained in the first email on 9 November 2022. In light of the information available, the panel was satisfied that Mr Wright has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Wright

The panel next considered whether it should proceed in the absence of Mr Wright. It had regard to Rule 21 and heard the submissions of Mr Edwards who invited the panel to continue in the absence of Mr Wright. He submitted that Mr Wright had voluntarily absented himself.

Mr Edwards submitted that Mr Wright has not responded to the Notice of Hearing and has disengaged with the NMC in relation to these proceedings. Mr Wright has not provided any information for the panel's consideration, save for the documents contained within the regulatory response bundle, the most recent of which are dated May 2021. Mr Edwards invited the panel to consider the potential inconvenience that an adjournment may have on witnesses, and the adverse impact which such adjournment may have on such witnesses'

memories. He said that there was no reason to believe that an adjournment would secure Mr Wright's attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel has decided to proceed in the absence of Mr Wright. In reaching this decision, the panel has considered carefully the submissions of Mr Edwards, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Wright;
- Mr Wright has not engaged with the NMC since around mid-2021, and has not responded to any of the letters sent to him about this hearing;
- There is no evidence to indicate that adjourning would secure Mr Wright's attendance at a future date;
- Three witnesses are on notice to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in January 2020;
- Further delay may have an adverse effect on the ability of witnesses to recall events accurately; and
- There is a strong public interest in the expeditious disposal of the case.

There may be some disadvantage to Mr Wright in proceeding in his absence. The panel noted that, despite the evidence of the NMC being sent to him at his registered email address, Mr Wright has not directly responded to the charges as drafted by the NMC. The panel does however have before it his responses to the allegations made during the course of the NMC investigation. Additionally, whilst he will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Wright's decisions to absent himself from the hearing, waive his right to attend, and/or be represented, and to not provide any further evidence since that received in about mid-2021 or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Wright. The panel will draw no adverse inference from Mr Wright's absence in its findings of fact.

Details of charge

That you a registered nurse;

1. On the 11 January 2020 when approached by Patient A failed to adopt de-escalation techniques:
   (a) By maintaining a safe distance from Patient A. **[PROVED]**
   (b) By adopting a side on stance to Patient A. **[PROVED]**
   (c) By having open hands at waist height. **[PROVED]**
   (d) By backing away from Patient A. **[PROVED]**
   (e) By removing yourself from the situation. **[PROVED]**
   (f) By requesting a Colleague to assist and/or de-escalate Patient A. **[NOT PROVED]**

2. On the 11 January 2020 physically and/or verbally abused Patient A by:
   (a) Pushing them. **[PROVED]**
   (b) Shouting at them. **[NOT PROVED]**

3. On the 11 January 2020 failed to preserve Patient A's safety by:
   (a) Not checking whether Patient A sustained any injuries after the fall. **[PROVED]**
   (b) Not seeking a doctor to review Patient A after the fall. **[PROVED]**
   (c) Not monitoring Patient A and/or instructing a Colleague to monitor Patient A after the fall. **[PROVED]**

4. On 11 January 2020 inaccurately completed the Datix by failing to record that Patient A had fallen to the floor. **[PROVED]**

5. Your actions in charge 4 were dishonest in that you deliberately sought to present an inaccurate report of the incident for your own benefit. **[PROVED]**

6. On 12 January 2020 inaccurately informed Colleague A;
   (a) Words to the effect of, *"you moved Patient A back".* **[PROVED]**
   (b) Words to the effect of, *"that Patient A had been assaulting you".* **[PROVED]**

7. Your actions in charge 6 were dishonest in that you deliberately presented Colleague A with an inaccurate account of the incident for your own benefit. **[PROVED]**

8. On 12 January 2020 failed to inform Colleague A that Patient A had fallen to the floor. **[PROVED]**

9. Your actions in charges 8 lacked integrity because you were seeking to minimise the incident for your own benefit. **[PROVED]**

In light of the above your fitness to practise is impaired by reason of your misconduct

Background

The charges arose whilst Mr Wright was employed as a registered nurse by North West Boroughs NHS Foundation Trust (the Trust) at Chesterton Unit (the Unit), a low-secure female mental health inpatient unit.

It is alleged that, at around 23:30 on 11 January 2020, Mr Wright physically and/or verbally abused a service user in his care by pushing her to the floor. It is further alleged that he completed a Datix report on 11 January 2020 ("the Datix") which contained an inaccurate reflection of the events. The CCTV footage of this incident was reviewed, and at this point concerns were raised about the accuracy of the Datix, and your conduct in this incident.

Mr Wright was invited to a disciplinary hearing on 3 June 2020, and subsequently dismissed by the Trust on the grounds of gross misconduct on 9 June 2020.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case including the CCTV footage, together with the submissions made by Mr Edwards on behalf of the NMC and the responses made by Mr Wright, contained in his regulatory response bundle.

The panel had viewed the CCTV footage of around 10 minutes from 11 January 2020, which shows the whole incident, including before and after the alleged incident. The CCTV footage was clear, and the panel was able to identify Mr Wright and Patient A. The footage was recorded from ceiling height, and shows the communal area where the incident took place. The CCTV footage was video only, and did not contain audio of the incident.

At the outset of the hearing, the panel viewed this CCTV footage in its entirety. The panel viewed this footage again in its entirety again at the close of the NMC's case. It took the opportunity to view relevant segments of the footage during in-camera sessions when making it decisions on facts.

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 over video link from the following witnesses called on behalf of the NMC:

- Colleague A: Band 6 Deputy Manager on the Unit, at the time the charges arose.
- Witness 2: Learning and Development Practitioner – Training Team Manager, at the time the charges arose.
- Witness 3: Ward manager on the Unit at the time the charges arose.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness evidence and documentary evidence provided by both the NMC and Mr Wright, including Mr Wright's response bundle, which was provided in 2021.

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

Charge 1

That you a registered nurse:

1. On the 11 January 2020 when approached by Patient A failed to adopt de-escalation techniques

Before making its findings on the individual charges at 1(a)-(f), the panel first considered the wording of charge 1. It bore in mind that, for Mr Wright to have "failed to adopt de-escalation techniques", the panel must first be satisfied that Mr Wright had a duty to adopt such techniques. In reaching its decision, it took into account all the evidence before it, and notably the evidence of Witness 2, and the Trust's Least Restrictive Intervention Policy.

The panel heard the oral evidence of Witness 2 in respect of the appropriate de-escalation techniques at the Trust, and the training which staff members undertook. It found Witness 2's oral evidence to be consistent with his witness statement, which sets out:

> *"Trust training is role specific, so mandatory training will differ for individuals depending on their role. Simon's role was working with inpatients, so he would be required to complete three levels of training: Conflict Resolution, Breakaway and Restrictive Physical Holding. In terms of compliance, Conflict Resolution training should be updated every three years and 12 monthly refreshers are required for Breakaway and Restrictive Physical Holding training."*

The panel heard, from Witness 2's oral evidence, that such training was a mandatory four-day training course at the start of a practitioner's employment at the Trust, followed by a two-day refresher training. He confirmed to the panel that Mr Wright had completed such training, and the panel had sight of Mr Wright's completed training records.

The panel had further regard to the documentary evidence before it, and noted the Trust's Least Restrictive Practice Policy, dated October 2019, sets out:

> ***"6.4 Individual Responsibilities***
>
> *6.4.1 All staff members have an individual responsibility to ensure they work within the legal and ethical framework that pertains to practice and interventions that would be defined as restrictive with a pro-active response to poor practice.*
>
> *6.4.2 All staff must ensure they comply with Trust policies relating to restrictive practice and contribute to activities designed to support a reduction or elimination of restrictive practices.*
>
> *6.4.3 All staff must ensure they are competent within their role and within the setting in which they are employed in order to meet the needs of the patients being cared for. Any gaps in knowledge, skills or practice in the area of restrictive practice and/or restrictive interventions must be raised swiftly by the individual to their supervising manager."*

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

> *". I was cornered and I had NO other option but to* ***"Attempt to De-Escalate"*** *which is my responsibility as a mental health nurse […]*
>
> *The facts are, I did "****Attempt to de-escalate…"*** *NOT all attempts to de-escalate are going to be successful and it is unrealistic to expect them to be."*

The panel had regard to all of the information before it and was satisfied that, on the balance of probabilities, Mr Wright had a duty to work in line with the Trust guidance and policies. It was satisfied that he had suitably completed all relevant training and therefore was subject to such policies and should have worked in line with them. The panel determined that, in the circumstances where it could be found that Mr Wright did not implement the de-escalation techniques advised in such training and guidance, it follows that he failed in the duty to adopt appropriate de-escalation techniques.

Charge 1a)

That you a registered nurse:

1. On the 11 January 2020 when approached by Patient A failed to adopt de-escalation techniques:
   (a) By maintaining a safe distance from Patient A.
   […]

This charge is found proved.

In reaching its decision, the panel took into account all of the evidence before it. It had particular regard to the CCTV footage of the incident.

The panel had regard to Mr Edward's submissions, that Mr Wright's actions on the CCTV footage of the incident demonstrate that Mr Wright failed to adopt de-escalation techniques by failing to maintain a safe distance when approached by Patient A.

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

> *"[Witness 2] claims I could **"Have Walked Away"** from after she swung her fist towards my face the first time and this is evident on the CCTV footage,*

but it is NOT evident from the CCTV footage. I reported during my initial fact-finding I have seen Patient A fly over tables and chairs to assault staff. I could NOT turn my back on Patient A as she assaults staff at their most vulnerable. I was cornered and I had NO other option but to ***"Attempt to De-Escalate"*** *which is my responsibility as a mental health nurse. My feelings during the incident have been disregarded, there is a constant attempt to minimise the risk Patient A presents to others and manipulate the facts. The layout of the room prevented me from leaving safely which if the scene had been visited would have been plainly obvious."*

The panel had particular regard to the CCTV footage of the incident and the movements and position of Mr Wright in respect of Patient A. It also bore in mind its finding that Mr Wright had a duty to follow the Trust Policy on de-escalation, which including a duty to keep a safe distance from service users in such circumstances.

When compared to the CCTV footage, the panel did not find Mr Wright's account to be plausible, it considered that Mr Wright was not standing directly in front of the furniture or the wall, and was not *"cornered"*. It concluded that he had the opportunity to step away from Patient A given the space around him at the relevant time. The panel noted that Mr Wright stepped towards Patient A, decreasing the distance between them. Accordingly, the panel found on the balance of probabilities that on the 11 January 2020, when approached by Patient A, Mr Wright failed to adopt de-escalation techniques and did not maintain a safe distance from Patient A.

The panel therefore found this charge proved.

Charge 1b)

That you a registered nurse:

1. On the 11 January 2020 when approached by Patient A failed to adopt de-escalation techniques:

[…]

(b) By adopting a side on stance to Patient A.

[…]

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it. It had particular regard to the CCTV footage of the incident.

The panel had regard to Mr Edward's submissions, that Mr Wright's actions on the CCTV footage of the incident demonstrate that Mr Wright failed to adopt de-escalation techniques by adopting a side on stance to Patient A.

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

> *"[Witness 2] **"Advocates"** having a side on stance and being a step and a kick away. Had I been a step and a kick away, I would have been backed against the chairs and I had moved out of the corner for this reason. [Witness 2] and [Mr 4] have never visited the incident location or reviewed the room layout. They have NOT worked out the scale, they have NOT identified CCTV issues or the CCTV distortion. Instead they have attempted to analyse poor quality footage repeatedly rather than doing anything practical and evidence based to remove any doubt or inconsistences."*

In his reflective piece, Mr Wright said:

> *"I fully accept I did not keep my hands down at my side nor did I have a side on stance. It is something I would always do in future in a similar position."*

The panel bore in mind its finding that Mr Wright had a duty to follow the Trust Policy on de-escalation, which included a duty to adopt a side on stance to service users in such circumstances.

The panel did not find Mr Wright's account to be plausible because it was contrary to the clear view which the panel could see of the incident from the CCTV footage. The panel observed from the CCTV footage that Mr Wright was positioned directly face on to Patient A and did not alter his position throughout the incident. Accordingly, the panel found, on the balance of probabilities that on the 11 January 2020, when approached by Patient A, Mr Wright failed to adopt de-escalation techniques by adopting a side on stance to Patient A.

The panel therefore found this charge proved.

Charge 1c)

That you a registered nurse:

1. On the 11 January 2020 when approached by Patient A failed to adopt de-escalation techniques:

   […]

   (c) By having open hands at waist height.

   […]

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it. It had particular regard to the CCTV footage of the incident.

The panel had regard to Mr Edward's submissions, that Mr Wright's actions on the CCTV footage of the incident demonstrate that Mr Wright failed to adopt de-escalation

techniques by raising his hands at Patient A, and failing to keep his hands open and at waist height.

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

> *"I did "**Attempt to De-Escalate**" the situation because I was "**Calm**". I do talk with my hands and this is how many people express themselves. Giving visuals can be effective when attempting to communicate with a person who doesn't have the capacity to engage in a meaningful conversation. It is evident from the CCTV I was using my hands while engaging Patient A attempting to rationalise her behaviour and feelings, and to redirect her. I had witnessed the NIC "Attempt to De-Escalate" which resulted in Patient A attempting to violently attack by punching."*

In his reflective piece, Mr Wright said:

> *"I fully accept I did not keep my hands down at my side nor did I have a side on stance. It is something I would always do in future in a similar position."*

The panel bore in mind its finding that Mr Wright had a duty to follow the Trust Policy on de-escalation, which including a duty to use open hands at waist height in such circumstances.

Having viewed the CCTV footage, the panel concluded that Mr Wright's right hand was raised above his waist and pointing at Patient A, and his left arm was at the height of his chest. Accordingly, the panel found on the balance of probabilities that on the 11 January 2020, when approached by Patient A, Mr Wright failed to adopt de-escalation techniques as he did not have open hands at waist height.

The panel therefore found this charge proved.

Charge 1d)

That you a registered nurse:

1. On the 11 January 2020 when approached by Patient A failed to adopt de-escalation techniques:

   […]

   (d) By backing away from Patient A.

   […]

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it. It had particular regard to the CCTV footage of the incident.

The panel had regard to Mr Edward's submissions, that Mr Wright's actions on the CCTV footage of the incident demonstrate that Mr Wright failed to adopt de-escalation techniques by backing away from Patient A.

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

> *"[Witness 2] **"Advocates"** having a side on stance and being a step and a kick away. Had I been a step and a kick away, I would have been backed against the chairs and I had moved out of the corner for this reason. [Witness 2] and [Mr 4] have never visited the incident location or reviewed the room layout. They have NOT worked out the scale, they have NOT identified CCTV issues or the CCTV distortion. Instead they have attempted*

to analyse poor quality footage repeatedly rather than doing anything practical and evidence based to remove any doubt or inconsistences."

The panel bore in mind its finding that Mr Wright had a duty to follow the Trust Policy on de-escalation, which including a duty to back away from service users in such circumstances.

Having viewed the CCTV footage, the panel did not find Mr Wright's account to be plausible, it observed that Mr Wright was not standing directly in front of the furniture or the wall, and was not *"cornered"*. It concluded that he had the opportunity to back away from Patient A given the space around him at the relevant time and failed to do so. The panel saw that, instead of backing away, Mr Wright stepped towards Patient A. Accordingly, the panel found, on the balance of probabilities that on the 11 January 2020, when approached by Patient A, Mr Wright failed to adopt de-escalation techniques by backing away from Patient A.

The panel therefore found this charge proved.

Charge 1e)

That you a registered nurse:

1. On the 11 January 2020 when approached by Patient A failed to adopt de-escalation techniques:

   […]

   (e) By removing yourself from the situation.

   […]

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it. It had particular regard to the CCTV footage of the incident.

The panel had regard to Mr Edward's submissions, that Mr Wright's actions on the CCTV footage of the incident demonstrate that Mr Wright failed to adopt de-escalation techniques by removing himself from the situation.

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

> *"[Witness 2]* ***"Advocates"*** *having a side on stance and being a step and a kick away. Had I been a step and a kick away, I would have been backed against the chairs and I had moved out of the corner for this reason. [Witness 2] and [Mr 4] have never visited the incident location or reviewed the room layout. They have NOT worked out the scale, they have NOT identified CCTV issues or the CCTV distortion. Instead they have attempted to analyse poor quality footage repeatedly rather than doing anything practical and evidence based to remove any doubt or inconsistences."*

The panel bore in mind its finding that Mr Wright had a duty to follow the Trust Policy on de-escalation, which including a duty remove himself from such circumstances.

Having viewed the CCTV footage, the panel did not find Mr Wright's account to be plausible, it observed that Mr Wright was not standing directly in front of the furniture or the wall, and was not *"cornered"*. It concluded that he had the opportunity to remove himself from the situation given the space around him at the relevant time, and he failed to do so. The panel saw that, instead of removing himself from the situation, Mr Wright stepped towards Patient A. Accordingly, the panel found, on the balance of probabilities that on the 11 January 2020, when approached by Patient A, Mr Wright failed to adopt de-escalation techniques by removing himself from the situation.

The panel therefore found this charge proved.

Charge 1f)

That you a registered nurse:

1. On the 11 January 2020 when approached by Patient A failed to adopt de-escalation techniques:

   […]

   (f) By requesting a Colleague to assist and/or de-escalate Patient A.

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence before it. It had particular regard to the CCTV footage of the incident.

The panel had regard to Mr Edward's submissions, that Mr Wright's actions on the CCTV footage of the incident demonstrate that Mr Wright failed to adopt de-escalation techniques by requesting a Colleague to assist and/or de-escalate Patient A.

The panel was mindful that there was no information before it as to Mr Wright's response to this charge.

The panel bore in mind its finding that Mr Wright had a duty to follow the Trust Policy on de-escalation, which includes a duty to request a Colleague to assist and/or de-escalate service users in such circumstances.

The panel had regard to the CCTV footage, which did not include audio of the incident. The panel had regard to the movements and gestures of Mr Wright and his colleagues during this incident. There were no clear attempts made by Mr Wright's colleagues to de-escalate Patient A. However, the panel could not determine, in the absence of audio

recording of the incident, that Mr Wright failed to request assistance from his colleagues to de-escalate Patient A. The panel therefore could not be satisfied, on the balance of probabilities, that on the 11 January 2020, when approached by Patient A, Mr Wright failed to adopt de-escalation techniques by requesting a Colleague to assist and/or de-escalate Patient A.

The panel therefore found this charge not proved.

Charge 2a)

That you a registered nurse:

2. On the 11 January 2020 physically and/or verbally abused Patient A by:

(a) Pushing them.

[…]

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it. It had particular regard to the CCTV footage of the incident.

The panel had regard to Mr Edward's submissions, that Mr Wright's actions on the CCTV footage of the incident demonstrate that Mr Wright physically abused Patient A by pushing them.

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

> *"Patient A aggressively swung her fist towards my face multiple times and I had a reasonable expectation that I was about to be assaulted. It has also been evidenced I asked Patient A to* ***"Step Back"*** *numerous times whilst*

she swung her fist towards my face. There is NO dispute I pushed Patient A away from going to punch me in the face, however, I do dispute it being referred to as a ***"Clear Push"*** *rather than self-defence and action to create space."*

The panel first considered whether Mr Wright pushed Patient A. It had regard to the CCTV footage of the incident in which it could clearly see the interaction between Mr Wright and Patient A. It concluded that, it was clear from this footage that Mr Wright pushed Patient A with one hand on each of her shoulders, and that Patient A fell backwards, her feet leaving the ground, to the floor, and travelled some distance from where Mr Wright was standing at the time.

Having found that Mr Wright pushed Patient A, the panel went on to consider whether this action amounted to physical abuse. The panel had regard to the CCTV footage, in which Patient A can be seen raising one or other of her hands, but not attempting to punch Mr Wright. It bore in mind its previous findings that Mr Wright should have, and failed to, employ appropriate de-escalation techniques. The panel concluded that, in the context of dealing with a vulnerable mental health patient, Mr Wright's action in pushing Patient A was disproportionate and did not amount to self-defence as claimed by Mr Wright, and therefore was considered by the panel to be physical abuse.

The panel therefore found this charge proved.

Charge 2b)

That you a registered nurse:

2. On the 11 January 2020 physically and/or verbally abused Patient A by:

    […]

    (b) Shouting at them.

This charge is found NOT proved.

In reaching this decision, the panel took into account all the evidence before it. It had particular regard to the CCTV footage of the incident.

The panel had regard to Mr Edward's submissions that, it is open to the panel to find that, from Mr Wright's actions on the CCTV footage of the incident, Mr Wright verbally abused Patient A by shouting at them.

The panel was mindful that there was no information before it as to Mr Wright's response to this charge.

The panel first considered whether Mr Wright shouted at Patient A. It had regard to the CCTV footage, which did not include audio of the incident. The panel had regard to the movements and gestures of Mr Wright, however, in the absence of audio of this incident, the panel could only see that Mr Wright was moving his mouth. The panel had no evidence before it of what was said by Mr Wright, and/or the volume and tone used by him. The panel therefore could not be satisfied, on the balance of probabilities, that on the 11 January 2020 Mr Wright shouted at Patient A.

The panel therefore found this charge not proved.

Charge 3a)

That you a registered nurse:

3. On the 11 January 2020 failed to preserve Patient A's safety by:

   (a) Not checking whether Patient A sustained any injuries after the fall

   […]

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it. It had particular regard to the CCTV footage of the incident.

The panel had regard to Mr Edward's submissions, that, it is open to the panel to find that, from Mr Wright's actions on the CCTV footage of the incident, Mr Wright failed to preserve Patient A's safety by not checking whether Patient A sustained any injuries after the fall.

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

> *"I explained during the hearing that I am unable to approach Patient A due to the events that had just unfolded, I would provoke a negative reaction. I did "**Check for Injuries"** and observed Patient A from a safe distance. When a patient continues to present in a threatening and hostile manner it is necessary to remain at a safe distance but I did ensure she was **"Check for Injuries"** before leaving the ward approx. 23:50hrs.*
>
> *I explained [Patient A] did NOT bang her head and there was NO altered state of consciousness, Patient A did NOT express any pain or discomfort Patient A's gait was normal, there were NO broken bones or bleeding. This is further supported by [Dr 8] statement who confirms she did NOT suffer any injury or adverse effect.*
>
> *[Ms 5] and [Ms 6] **"Check"** on Patient A welfare, and they BOTH reported back to [Ms 7] and me. [Ms 7] observed Patient A through the observation window and hourly **"Check"** continued throughout the night as per observation allocation sheet.*

I have maintained throughout this process that I did NOT see Patient A fall backwards Patient A took a few steps backwards, dropped to the floor to maintain control of the situation and got straight back up because that is what she does and has done many times before. If I had seen Patient A fall backwards then I would have documented it and ensured the on-call doctor was requested before leaving the ward."

The panel had particular regard to the CCTV footage of the incident and the movements and position of Mr Wright in respect of Patient A. It considered whether Mr Wright had a duty preserve Patient A's safety. The panel concluded that such duty existed as a result of Mr Wright's role as a registered nurse, with duties and responsibilities to Patient A and other service users in his care, as set out by the Trust as his employer and under the NMC Code of Conduct.

The panel had regard to the CCTV footage, and concluded that Mr Wright's account of the incident was inconsistent with this evidence. The panel had noted Mr Wright's actions following Patient A falling to the ground, in which he continued to engage with Patient A by talking to her and pointing his finger, before returning to his seat in the corner of the room. The panel noted that there was no time during the CCTV that Mr Wright approached Patient A to check whether she had sustained any injuries. The CCTV footage continued for a period of approximately five minutes after the incident took place. Having established that Mr Wright had a duty to preserve Patient A's safety, the panel found that, on the balance of probabilities, on 11 January 2020, Mr Wright failed to do so by not checking whether Patient A sustained any injuries after the fall.

The panel therefore found this charge proved.

Charge 3b)

That you a registered nurse:

3. On the 11 January 2020 failed to preserve Patient A's safety by:

    […]

    (b) Not seeking a doctor to review Patient A after the fall.

    […]

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it. It had particular regard to the evidence of Witness 3.

The panel found the oral evidence of Witness 3 to be clear and consistent with her witness statement, dated 8 June 2021, which sets out:

> *"After I viewed the CCTV I also spoke to Patient A, who said that she had been pushed to the floor. I cannot recall whether she told me who had pushed her. Because I saw the patient fell to the floor in the CCTV footage and also because I had spoken to the patient myself, I asked Dr 8 to check on and examine her. I understand that [Dr 8] completed a body map on this occasion, but I did not see that document. It will be recorded in the patient's notes if she had suffered any injuries, but I do not think there was any redness to the area and I do not recall there being any injuries.*
>
> *I would always expect a doctor to be asked to review a patient if they had had a fall, to make sure that no injury had been sustained. That it is something that should have done immediately following the incident. If a patient has a fall it is everybody's responsibility to safeguard them. Anybody on that shift could therefore have asked for a doctor to review Patient A, regardless of their band."*

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

> *"I have maintained throughout this process that I did NOT see Patient A fall backwards Patient A took a few steps backwards, dropped to the floor to maintain control of the situation and got straight back up because that is what she does and has done many times before. If I had seen Patient A fall backwards then I would have documented it and ensured the on-call doctor was requested before leaving the ward."*

The panel took into account all of the evidence before it. It considered whether Mr Wright had a duty preserve Patient A's safety. The panel concluded that such duty existed as a result of Mr Wright's role as a registered nurse, with duties and responsibilities to Patient A and other service users in his care, as set out by the Trust as his employer and under the NMC Code of Conduct.

The panel preferred the account of Witness 3 to that of Mr Wright. It found that Witness 3 gave clear and consistent evidence that she was the person who called the Doctor to attend to Patient A, on 12 January 2020, and that a doctor had not been sought to review Patient A following her falling to the ground before this time. Having established that Mr Wright had a duty to preserve Patient A's safety, the panel found that, on the balance of probabilities, on 11 January 2020, Mr Wright failed to do so by not seeking a doctor to review Patient A after the fall.

The panel therefore found this charge proved.

Charge 3c)

That you a registered nurse:

3. On the 11 January 2020 failed to preserve Patient A's safety by:

[…]

(c) Not monitoring Patient A and/or instructing a Colleague to monitor Patient A after the fall.

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it.

The panel had regard to Mr Edward's submissions, that there is no evidence before the panel to suggest that Mr Wright preserved Patient A's safety by monitoring her and/or instructing a colleague to monitor her after the fall.

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

> *"[Ms 5] and [Ms 6] **"Check"** on Patient A welfare, and they BOTH reported back to [Ms 7] and me. [Ms 7] observed Patient A through the observation window and hourly **"Check"** continued throughout the night as per observation allocation sheet.*
>
> *I have maintained throughout this process that I did NOT see Patient A fall backwards Patient A took a few steps backwards, dropped to the floor to maintain control of the situation and got straight back up because that is what she does and has done many times before. If I had seen Patient A fall backwards then I would have documented it and ensured the on-call doctor was requested before leaving the ward."*

The panel took into account all of the evidence before it. It considered whether Mr Wright had a duty preserve Patient A's safety. The panel concluded that such duty existed as a result of Mr Wright's role as a registered nurse, with duties and responsibilities to Patient A

and other service users in his care, as set out by the Trust as his employer and under the NMC Code of Conduct.

The panel had regard to the CCTV footage of the incident, and noted that, shortly after Patient A was pushed to the floor, Patient A left the communal room followed by another member of staff. Mr Wright returned to sit in the corner of the room for the remainder of the CCTV footage. The panel concluded that, on the balance of probabilities, Mr Wright did not make any attempt to monitor Patient A after the fall.

The panel therefore found this charge proved on the first limb. It did not go on to consider the alternative; whether Mr Wright failed to preserve Patient A's safety by not instructing a Colleague to monitor Patient A after the fall.

Charge 4)

That you a registered nurse:

4. On the 11 January 2020 inaccurately completed the Datix by failing to record that Patient A had fallen to the floor.

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it. It had particular regard to the CCTV footage, and the Datix entry dated 11 January 2020, in which Mr Wright provided the description of the incident as:

> *"Patient A knocked on the nurses office door to request NRT inhalator, NIC administered. Whilst in the clinic Patient A threatened physical assault/attack on NIC [nurse in charge].*

Patient A knocked on nurses office again verbally abusive and threatening towards NIC and spare nurse [Mr Wright]. Patient A threatening to physically assault. Patient A attempted to punch NIC and spare nurse raised their voice "go sit down".

Patient [A] started targeting spare nurse, verbally abusive and threatening. Patient [A] squared up to spare nurse and threatened to assault by raising their right arm fist clenched. Spare nurse pushed Patient A back and advised not to threaten/ assault staff."

The panel also took into account Witness 3's evidence, that she first saw the Datix entry on 12 January 2022 and was not aware that Patient A had fallen to the floor until she reviewed the CCTV footage of the incident also on the following day, as there was no mention of Patient A's fall in the Datix entry.

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

"The incident was reported and escalated to [Colleague A], Deputy Manager. I have acknowledged my documentation did not fully reflect the incident and I documented the incident as I recalled it. Management have never had issue with my previous DATIX's and this is a first which I have been advised was not up to the expected standard.

I completed the DATIX because I felt that was the right thing to do and it is policy following an incident. The Datix and incident must then be reviewed by management. [Ms 5] and I reported the incident to ward management in the morning. I described a violent assault and the use of force to defend myself, [Colleague A], agreed to review the incident. [Ms 7] completed the RiO progress note and handed the incident over to the morning staff. NONE

of this has been included from the hearing despite it being discussed because it does NOT support the panel's decision to dismiss me."

In his FtP [Fitness to Practise] Reflective Account Form, Mr Wright set out:

"Inaccurate record keeping – [Ms 7] (NIC) documented the incident in the patients RiO progress note and handed the incident over to the morning staff. I completed the DATIX as per policy recording a violent attack and use of force to defend myself. I did not include Patient A going to the floor following direction from [Witness 3] (WM) in the previous staff meeting. [Witness 3] (WM) had advised DATIX reporting to include multiple incidents and to be brief to reduce paperwork. I did not document the actions taken which included Patient A's welfare check immediately after the incident and throughout the night. In the morning I handed the incident over to [Colleague A] (DWM) and requested the incident be reviewed which included reviewing the CCTV footage. I was transparent and open handing over the incident in the company of [Ms 5] (HCA) who had been witness. I had never used breakaway or self-defence before and [Colleague A] (DWM) agreed to review the incident."

The panel had regard to the incident in the CCTV footage and bore in mind its finding at charge 2a, that Mr Wright pushed Patient A. It noted that there is no mention of Patient A falling to the floor, in the Datix entry completed by Mr Wright. It also accepted Witness 3's evidence, that she was not aware of such fall until she reviewed the CCTV footage. The panel therefore concluded that, on the balance of probabilities, Mr Wright inaccurately completed the Datix by failing to record that Patient A had fallen to the floor.

The panel therefore found this charge proved.

Charge 5)

That you a registered nurse:

5. Your actions in charge 4 were dishonest in that you deliberately sought to present an inaccurate report of the incident for your own benefit.

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it and the advice of the legal assessor.

In reaching this decision, the panel had regard to the test for dishonesty set out by Lord Hughes in paragraph 74 of *Ivey v Genting Casinos UK Ltd t/a Crockfords* [2017] UKSC 67:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts…. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

In respect of the panel's consideration of Mr Wright's subjective knowledge as to whether he believed that his actions at charge 4 were dishonest, it had regard to Mr Wright's regulatory responses to the NMC concerns, provided in 2021, which set out:

> *"The incident was recorded via DATIX report, hand over to the morning shift and escalation to ward management for their review. On reflection my documentation should have included a clearer account about Patient A falling to the floor. I knew the CCTV footage would be viewed as all incidents of violence and aggression involving a member of staff were reviewed via*

the CCTV footage as common practice on the unit. There was never any intention to hide anything or be dishonest."

The panel had regard to the Datix, and accepted the evidence of Witness 3 that, although other parts of this report may have been amended by other employees of the Trust subsequent to the report being created, the part of the Datix which relates to Mr Wright's description of the incident remains unchanged.

The panel concluded that, on the balance of probabilities, Mr Wright had willingly and knowingly inaccurately completed the Datix in an attempt to minimise the impact of his failing upon him and his career. The panel determined that the selective approach used by Mr Wright in completing the Datix was done with the intention to mislead his employers and avoiding telling them that he had pushed Patient A over, likely in the knowledge that his failings could have opened the potential for disciplinary and regulatory scrutiny.

The panel then applied the standards of ordinary decent people. It concluded that, by selectively completing the Datix in a deliberate attempt to present an inaccurate report of the incident for his own benefit, an ordinary decent person would find Mr Wright's actions to be dishonest.

The panel therefore finds this charge proved.

Charge 6a)

That you a registered nurse:

6. On 12 January 2020 inaccurately informed Colleague A;

   (a) Words to the effect of, *"you moved Patient A back".*

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it. It had particular regard to the evidence of Colleague A and the CCTV footage.

The panel found the oral evidence of Colleague A to be credible and consistent with her witness statement, dated 8 June 2021, which sets out:

> *"The registrant went ahead to explain that he had been with a patient by the name of Patient A […] who had been verbally aggressive the night before. The registrant added that patient A then started to assault him, the registrant added that Patient A was aggressive and abusive as such he moved Patient A back to resolve this instead of calling for assistance from other staff members.*
>
> *If there was an incident within the ward, we would expect staff members to respond to the incident together however the registrant informed me that he moved Patient A on his own."*

Colleague A demonstrated for the panel, in the course of her oral evidence, how Mr Wright said that he moved Patient A back. It noted that the demonstration of force by Colleague A was significantly less than the force used by Mr Wright in the CCTV footage.

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

> *"The incident was reported and escalated to [Colleague A], Deputy Manager. I have acknowledged my documentation did not fully reflect the incident and I documented the incident as I recalled it."*

The panel observed the CCTV footage, in which Mr Wright can be seen to push Patient A, and Patient A travels a distance as a result of the forced used in the push. In all the

circumstances, the panel concluded that Mr Wright's account of the incident to Colleague A was inaccurate, in that he minimised the force he used towards Patient A by saying he *"moved her back".* The panel therefore found that, on the balance of probabilities, on 12 January 2020, Mr Wright inaccurately informed Colleague A words to the effect of *"you moved Patient A back"*.

The panel therefore finds this charge proved.

Charge 6b)

That you a registered nurse:

6. On 12 January 2020 inaccurately informed Colleague A;

(b) Words to the effect of, *"that Patient A had been assaulting you".*

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it. It had particular regard to the evidence of Colleague A and the CCTV footage.

The panel found the oral evidence of Colleague A to be credible and consistent with her witness statement, dated 8 June 2021, which sets out:

> *"The registrant went ahead to explain that he had been with a patient by the name of Patient A […] who had been verbally aggressive the night before. The registrant added that patient A then started to assault him, the registrant added that Patient A was aggressive and abusive as such he moved Patient A back to resolve this instead of calling for assistance from other staff members."*

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

> *"The facts are Patient A immediately became abusive and hostile jabbing her finger towards my face demanding "You Owe Me A Fucking Apology"*

And

> *"Patient A came out of the tv lounge instantly verbally abusing and threatening physical violence towards me Patient A swung their fist towards my face multiple times and I pushed back to create space."*

The panel had regard to all of the evidence before it, and noted that the CCTV footage does not include audio, therefore the panel was unable to establish what was said by either Mr Wright or Patient A. The panel found the evidence of Colleague A to be clear and cogent. She could recall what was said to her and the panel concluded that it had no reason to doubt this account. The panel noted that some of Mr Wright's descriptions were consistent with the CCTV footage, such as Patient A raising her hand to him, however, the panel concluded that his description of *"Patient A assaulting him"* was inaccurate. Accordingly, the panel found that, on the balance of probabilities, on 12 January 2020, Mr Wright inaccurately informed Colleague A words to the effect of that *"Patient A had been assaulting him".*

The panel therefore finds this charge proved.

Charge 7)

That you a registered nurse:

7. Your actions in charge 6 were dishonest in that you deliberately sought to present Colleague A with an inaccurate account of the incident for your own benefit.

This charge is found proved.

In reaching this decision, the panel took into account the evidence before it and the advice of the legal assessor.

In reaching this decision, the panel had regard to the test for dishonesty set out by Lord Hughes in paragraph 74 of *Ivey v Genting Casinos.*

In respect of the panel's consideration of Mr Wright's subjective knowledge as to whether he believed that his actions at charge 6 were dishonest, it had regard to Mr Wright's regulatory responses to the NMC concerns, provided in 2021, which set out:

> *"The incident was reported and escalated to [Colleague A], Deputy Manager. I have acknowledged my documentation did not fully reflect the incident and I documented the incident as I recalled it."*

The panel concluded that, on the balance of probabilities, Mr Wright had willingly and knowingly inaccurately misled Colleague A by selectively detailing the incident on 11 January 2020 in an attempt to minimise the impact of his failing upon him and his career. The panel determined that the selective approach used by Mr Wright in reporting the incident to Colleague A was done with the intention to mislead his employers and to avoid telling them that he had pushed Patient A over, in the knowledge that his failings could have resulted in disciplinary and regulatory scrutiny.

The panel then applied the standards of ordinary decent people. It concluded that, by selectively reporting the incident to Colleague A in a deliberate attempt to present an

inaccurate report of the incident for his own benefit, an ordinary decent person would find Mr Wright's actions to be dishonest.

The panel therefore finds this charge proved.

Charge 8)

That you a registered nurse:

8. On 12 January 2020 failed to inform Colleague A that Patient A had fallen to the floor.

This charge is found proved.

In reaching this decision, the panel took into account all the evidence before it. It had particular regard to the evidence of Colleague A and the CCTV footage.

The panel found the oral evidence of Colleague A to be credible and consistent with her witness statement, dated 8 June 2021, which sets out:

> *"The registrant went ahead to explain that he had been with a patient by the name of Patient A […] who had been verbally aggressive the night before. The registrant added that patient A then started to assault him, the registrant added that Patient A was aggressive and abusive as such he moved Patient A back to resolve this instead of calling for assistance from other staff members."*

The panel found Colleague A's evidence to be credible and consistent. It noted that she was clear that she was unaware that Patient A had fallen to the floor until the CCTV footage of this incident was reviewed by her colleagues at a later time.

The panel was mindful that Mr Wright has not directly responded to this charge as drafted by the NMC, however it also bore in mind his responses to the regulatory concerns, which he provided in 2021, in which he said:

> *"The incident was reported and escalated to [Colleague A], Deputy Manager. I have acknowledged my documentation did not fully reflect the incident and I documented the incident as I recalled it."*

The panel preferred the evidence of Colleague A in relation to this charge, which it found to be credible and consistent. The panel had regard to its findings in relation to charge 2a that Patient A was pushed by Mr Wright, and its findings in respect of charges 6 and 7, that Mr Wright selectively, inaccurately and dishonestly reported this incident to Colleague A. The panel noted that it is clear on the CCTV that Patient A fell to the floor, and it would be the duty of any registered nurse to include such detail in a report to their manager. The panel therefore found, on the balance of probabilities, that on 12 January 2020, Mr Wright failed to inform Colleague A that Patient A had fallen to the floor.

The panel therefore found this charge proved.

Charge 9)

That you a registered nurse:

9. Your actions in charges 8 lacked integrity because you were seeking to minimise the incident for your own benefit.

This charge is found proved.

The panel considered integrity in this context to mean the overarching principles, including the ethical and moral codes, expected of registered nurses in their practice. This includes a nurse's duty to truthfully and accurately report incidents which relate to patient safety. The panel took into account its finding in relation to charge 8, and concluded that Mr

Wright's actions lacked integrity. It found that, in selectively reporting the details of the incident to Colleague A, he lacked openness, transparency and the moral fortitude expected of a registered nurse.

The panel found that Mr Wright failed to fully disclose to Colleague A the details of the incident because he sought to prioritise his own interests over those of Patient A. The panel determined that the selective approach used by Mr Wright in reporting the incident to Colleague A was done for his own benefit to avoid telling them that he had pushed Patient A over, in the knowledge that his failings could have opened the potential for disciplinary and regulatory scrutiny. Accordingly, the panel found that, on the balance of probabilities, Mr Wright's actions in charge 8 lacked integrity because he was seeking to minimise the incident for his own behalf.

The panel therefore found this charge 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 Mr Wright'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 Wright's fitness to practise is currently impaired as a result of that misconduct.

Submissions 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.'*

Mr Edwards 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.

Mr Edwards identified the specific, relevant standards where Mr Wright's actions amounted to misconduct. He submitted that the following parts of the Code have been breached and that the panel, of its own volition, may wish to consider other parts of the Code breached which amount to misconduct:

> ***"1. Treat people as individuals and uphold their dignity***
>
> *To achieve this, you must:*
>
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***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

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

10.3 complete 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

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

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to."

Mr Edwards submitted that the facts found proved do, individually and cumulatively, amount to misconduct and fall well below the standards expected of a registered nurse. He submitted that Mr Wright's actions are deplorable in all the circumstances of the case. He stated that Mr Wright lied about what had happened, including by filling out the Datix and failing to inform Colleague A that Patient A had fallen. He submitted that Mr Wright acted in pursuit of his own benefit, and he invited the panel to find the facts proved as amounting to misconduct.

Submissions on impairment

Mr Edwards moved on to the issue of impairment and addressed the panel on the need to have regard to protecting 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. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin), and *Cohen v GMC* 2008 EWHC 581.

Mr Edwards referred the panel to the four limbs in the case of *Grant*, namely:

> *"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."*

Mr Edwards submitted that all four limbs in the case of *Grant* as laid out above were engaged and that Mr Wright's actions brought the profession into disrepute. He submitted that Mr Wright breached the fundamental tenets of the professions and acted dishonestly, which go to the heart of the nursing profession. He submitted that not finding Mr Wright's practice impaired will undermine the public confidence in the profession as a whole. Mr Edwards stated that the panel may consider that some of his conduct is remediable, however he submitted that the dishonesty element is more difficult to remedy. He submitted that there was no evidence before the panel to demonstrate that Mr Wright has remediated the concerns and no evidence that Mr Wright has undertaken recent training. Mr Edwards referred to Mr Wright's response bundle and submitted that Mr Wright's training records predates the incidents in the charges, and that there is no evidence before the panel that Mr Wright has undertaken further training.

Mr Edwards submitted that given the lack of information before the panel regarding Mr Wright improving and addressing his own practice, and in light of Mr Wright's response to the allegations in his written response early on and throughout, Mr Wright demonstrates a lack of insight and an understanding of his actions. He stated that in Mr Wright's early response, Mr Wright repeatedly blamed Patient A for what happened on the day of the incident rather than looking at his own actions and failings. Mr Edwards submitted that Mr Wright failed to adopt the de-escalation techniques that he had been trained to use. He submitted that Mr Wright was faced with a vulnerable patient and that it was incumbent on Mr Wright to act in a professional way.

Mr Edwards submitted that Mr Wright showed some reflection in his response bundle; Mr Wright started to address the events which occurred on 11 January 2020 and the related concerns. He submitted that Mr Wright's reflective piece does not undo his actions or exonerate him from the wrongdoing. He stated that in fairness to Mr Wright, the panel may have difficulty forming a view here. He submitted that on one hand Mr Wright accepted that his actions were wrong and stated that he was shocked at what happened after viewing the CCTV footage. Mr Edwards submitted that on the other hand, Mr Wright then

sought to minimize what had happened by stating that the CCTV footage *"does not show everything"*.

Mr Edwards therefore invited the panel to find Mr Wright's practice impaired on the grounds of public protection and public interest. He stated that the charges found proved are serious and include repeated dishonesty from Mr Wright in order to benefit his own ends. He submitted that not making a finding of impairment would undermine the public confidence in the profession and in the NMC as a regulator, and that Mr Wright still presents a risk to members of the public if his practice is not restricted.

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, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin). The panel took into account further advice from the legal assessor in relation to the case of *Schodlok v GMC* [2013] EWHC Civ 769. It was advised that although some charges, individually less minor and not serious enough, as a result of being linked, may be collectively found as misconduct.

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

"1. Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

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

8.3 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

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:

10.2 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 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

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to."

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that that charges 2 (a), 3 (a) – (c), 4, 5, 6(a) – (b), 7, 8 and 9, as found proved, amount to misconduct. The panel did not find that charge 1(a) – (e) amounted to misconduct.

Charge 1

The panel considered that charge 1 and its sub-charges, sub-charge (a) – (e), relate to one single incident of failing to adopt the relevant de-escalation techniques. It took into account that Mr Wright had a duty to adopt de-escalation techniques as trained and a duty to follow the Trust's policies in that respect. However, the panel did not find that a breach of the Trust's policy, in the context of this charge, in isolation, amounts to misconduct.

Charge 2(a)

Based on the evidence before it, the panel found that Mr Wright's actions in relation to charge 2(a) amounted to serious misconduct. The panel agreed with the NMC's submissions in respect to this charge and observed that any member of the profession or the wider public would find Mr Wright's actions deplorable.

Charge 3(a) – (c)

The panel took into account Mr Wright's response as provided in his response bundle. It noted that the failures laid out under charge 3 were denied by Mr Wright. It considered that the duty of a registered nurse, as set out by the Code, includes the duty to maintain patient safety. It took into account that there was no evidence before it to support that Mr Wright had asked anyone to check on Patient A. The panel therefore found that charge 3 amounted to misconduct.

Charge 4

The panel took into account that the Datix is used to report adverse events. It took into account that the action under charge 4 is a single incident and that charge 4, in isolation, amounts to a clear breach of Code 10. It bore in mind that a mere breach of the Code does not necessary amount to misconduct.

However, the panel was satisfied that, based on the evidence before it, the incident involving Patient A was a serious incident, in that Mr Wright pushed Patient A to the floor and did not record this in the Datix. The panel was of the view that whilst it can be argued that, on its own, charge 4 as worded does not amount to misconduct, taking into account the circumstances of the case and the context behind the incident, charge 4 amounts to misconduct.

Charge 5

The panel was satisfied that, based on the evidence before it, Mr Wright knowingly gave an inaccurate picture in his description of the event in the Datix and that he did so with the intention to mislead. The panel therefore found that charge 5 amounted to misconduct.

Charge 6(a)

The panel was satisfied that, based on the information before it, charged 6a amounts to misconduct.

Charge 6(b)

The panel was satisfied that, based on the information before it, charged 6b amounts to misconduct. It took into account the evidence of Colleague A. It determined that Mr Wright created a false impression of the events to Colleague A for his own benefit. The panel found that charge 6(b) amounts to a serious breach of the Code and amounts to misconduct.

Charge 7

The panel was satisfied that, based on the evidence before it, Mr Wright acted dishonestly and attempted to present Colleague A with inaccurate information for his own benefit. The panel found that charge 7 amounts to misconduct.

Charge 8

Taking into account all the circumstances of the case and the context behind the events giving rise to the charge, the panel was satisfied that, based on the evidence before it, charge 8 amounts to a serious breach of the Code and to misconduct.

Charge 9

Taking into account all the circumstances of the case and the context behind the events giving rise to the charge, the panel was satisfied that, based on the evidence before it, charge 8 amounts to a serious breach of the Code and to misconduct. It was satisfied that Mr Wright did not act with integrity in seeking to minimise the incident for his own benefit.

Overall, the panel found that Mr Wright's 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, Mr Wright'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. 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 finds that Patient A was put at risk of physical and emotional harm as a result of Mr Wright's misconduct. It found that Mr Wright's actions following Patient A's fall demonstrate a pattern of dishonest behaviour. It concluded that Mr Wright's misconduct

had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty as extremely serious.

Regarding insight, the panel took into account Mr Wright's response bundle, his reflective piece and the testimonials of Mr Wright's colleagues in his favour. It determined that, whilst Mr Wright demonstrated some insight, this insight is in its early stages. However, it noted that Mr Wright has not engaged with the NMC since the middle of 2021.

The panel was satisfied that the misconduct in relation to some charges may be capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Wright has taken steps to strengthen his practice. The panel noted that Mr Wright, in his reflections dated 28 January 2021 for the interim order review, he documented actions he had taken to address managing violence and aggression. It noted however that this reflective piece was unsupported by evidence, such as certificates of formal training.

The panel is therefore of the view that the risk of repetition remains. The panel determined 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. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Wright's fitness to practise is also impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Wright's 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 Mr Wright off the register. The effect of this order is that the NMC register will show that Mr Wright has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been produced 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 Edwards submitted that issue of sanction is a matter for the panel alone, however he invited it to impose a striking-off order. He said that Mr Wright's conduct raises fundamental questions about his professionalism and the trust and confidence which the public can place in the nursing profession.

Mr Edwards submitted that the facts and misconduct found by the panel breach the fundamental tenets of a nurse, including the duty of candour. He outlined that the panel has found that Mr Wright attempted to cover up his wrongdoing in causing a vulnerable patient a significant risk of harm by pushing Patient A with force, and then going on to attempt to minimise his actions and provide false information about what happened, in order to benefit himself.

Mr Edwards submitted the following to be aggravating features in this matter:

- Patient A was a vulnerable patient with severe mental health problems, who was housed in a low-secure mental health unit;

- Mr Wright breached his duty of candour;
- Mr Wright's actions demonstrated a lack of professionalism and a breach of the trust which patients, and the public placed in him as a nurse;
- Mr Wright demonstrated a serious lack of integrity following the incident where he pushed Patient A; and
- Mr Wright put Patient A at a serious risk of harm.

Mr Edwards submitted the following to be mitigating features in this matter:

- Mr Wright showed limited insight into his actions, although this insight was demonstrated some time after the incident occurred;
- The charges related to a one-off incident which occurred one a single night shift;
- The NMC has not received any previous referrals or concerns about Mr Wright's fitness to practise; and
- The positive references contained within the registrant response bundle, although Mr Edwards highlighted that these testimonials are not recent.

In respect of the sanctions available, Mr Edwards submitted that Mr Wright's dishonesty was repeated, and therefore so serious that a temporary removal from the NMC register would be insufficient and inappropriate in the circumstances. He submitted that, given the panel's findings on dishonesty, a conditions of practice order is inappropriate as such dishonesty cannot be sufficiently addressed through a conditions of practice order.

Mr Edwards submitted that a striking off order is the only proportionate and appropriate sanction to be imposed in such a case, where the panel has found that Mr Wright physically abused a vulnerable patient and then demonstrated subsequent repeated dishonesty in order to hide and minimise his actions. Mr Edwards further submitted that a striking-off order is also necessary to maintain public confidence in the nursing profession and the NMC as a regulator.

Mr Edwards referenced aspects Mr Wright's reflective piece which was drafted for the attention of the Case Examiner.

Decision and reasons on sanction

Having found Mr Wright'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:

- Mr Wright's abuse of a position of trust towards a vulnerable patient in his care;
- Conduct which put patients at risk of suffering harm;
- Mr Wright's dishonesty in the workplace; and
- Mr Wright's lack of integrity.

The panel also took into account the following mitigating features:

- Mr Wright has demonstrated limited insight into his failings; and
- Colleague A, in her oral evidence, spoke positively of Mr Wright's competence as a nurse.

Before going on to consider the individual sanctions, the panel first had regard to the NMC guidance on serious charges for cases involving dishonesty. The panel bore in mind that Mr Wright's dishonesty stemmed from his attempts to cover up and mislead his employers in relation to a one-off and spontaneous incident of physical abuse, in pushing Patient A to the floor. The panel concluded that, although the incident of abuse was a single and

isolated event, Mr Wright's dishonesty in relation to his reporting and recording of this event was sustained and repeated.

The panel considered the following sections of the NMC guidance on serious charges for cases involving dishonesty were engaged in this matter:

> *"In every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*
>
> - *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
> - *misuse of power*
> - *vulnerable victims*
> - *[…]*
> - *direct risk to patients*
> - *premeditated, systematic or longstanding deception*
>
> *Dishonest conduct will generally be less serious in cases of:*
>
> - *[…]*
> - *[…]*
> - *no direct personal gain*
> - *[…]"*

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the findings of the panel and the seriousness of the case. The

panel decided that it would be neither proportionate nor 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 Mr Wright'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 Wright's misconduct was not at the lower end of the spectrum, and the dishonesty found was at the upper spectrum of seriousness. Accordingly, the panel concluded 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 Wright's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case, which included physical abuse of Patient A and subsequent sustained dishonesty in relation to his reporting and recording of this event.

The panel concluded that misconduct identified in this case did not relate to Mr Wright's general clinical competencies as a nurse, but instead concerned attitudinal issues which cannot be easily addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Wright's registration would not adequately address the seriousness of this case and mark the public interest concerns identified by the panel.

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 the following factor is apparent:

- *No evidence of repetition of behaviour since the incident;*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel decided that the serious breach of the fundamental tenets of the profession evidenced by Mr Wright's actions is fundamentally incompatible with Mr Wright remaining on the register. The panel concluded that the misconduct in this matter was serious, and the public interest would not be properly served were Mr Wright not removed from the register. The panel acknowledged that, despite Mr Wright's non-engagement with the NMC since mid-2021, the panel had before it Mr Wright's reflections, which demonstrated limited insight and his acknowledgment of where he may have failed in his duties as a nurse, which set out:

> *"I cannot apologise to patient A enough. I can honestly say I had no malicious intentions towards Patient A and I was not angry towards her. It is never right to push someone over no matter what the circumstances and is not something I would do in or out of work. It is certainly not something I would ever agree was right with a patient in my care. I did try to manage a situation as best I could, and I got it wrong and for that I am truly sorry."*

However, the panel concluded that the nature of the charges is so serious, and the public interest so high, in the circumstances where Mr Wright has not engaged with the NMC since mid-2021, he is unable to sufficiently demonstrate that he is capable of practising as a safe and effective nurse. In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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?*

Mr Wright's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Wright's actions were serious and to allow him 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 Mr Wright's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, 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.

This will be confirmed to Mr Wright in writing.

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 Mr Wright's 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 took account of the submissions made by Mr Edwards. He submitted that an interim suspension order for a period of 18 months is necessary for public protection, and it is in the wider public interest, given the seriousness of the facts found proved and the sanction imposed by the panel.

Decision and reasons on interim order

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 to protect the public and serve the public interest over the period of any appeal which Mr Wright may make.

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

That concludes this determination.