Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ
(Monday, 4 April – Tuesday, 12 April 2022)
(Monday, 28 November – Wednesday, 30 November 2022)

Virtual Hearing
(Thursday, 24 November – Friday, 25 November 2022)

Name of registrant:	**Miss Paula Fisher**
NMC PIN:	86A0061E
Part(s) of the register:	Registered Nurse – Sub part 1 Mental Health Nursing - 1 April 2004
Relevant Location:	Lancashire
Type of case:	Misconduct
Panel members:	Melissa D'Mello (Chair, Lay member) Mark Gibson (Registrant member) David Anderson (Lay member)
Legal Assessor:	Ben Stephenson
Hearings Coordinator:	Parys Lanlehin-Dobson (Monday, 4 April, Wednesday, 6 April – Tuesday, 12 April 2022) Phil Austin (Tuesday, 5 April 2022) Samiz Mustak (Thursday, 24 November – Friday, 25 November 2022) Renee Melton-Klein (28-30 November 2022)
Nursing and Midwifery Council:	Represented by Raj Joshi, Case Presenter
Miss Fisher:	Present and represented by Laura Bayley, instructed by Thompson Solicitors
Facts proved:	Charges 1, 2, 3 and 4 (By admission)
Facts not proved:	None

Fitness to practise:	**Impaired (on public interest grounds alone)**
Sanction:	**Strike Off**
Interim order:	**Interim Suspension Order (18 months)**

Details of charge

That you, a registered nurse:

1) Failed to maintain professional boundaries with Patient A in that you entered into a sexual relationship with him for an unknown period of around a few months between 2011 and 2014.

2) Continued to act as Patient A's care coordinator after you entered into a sexual relationship with him.

3) Failed to disclose to Greater Manchester Mental health NHS Trust ("the Trust") that you had entered into a sexual relationship with Patient A.

4) Your conduct in Charge 3, above, was dishonest in that you intended to conceal from the Trust that you had breached professional boundaries with Patient A.

   Or in the alternative:

   Your conduct in Charge 3, above, was a failure to comply with your duty of candour in that you failed to disclose that you had breached professional boundaries with Patient A to the Trust.

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

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

At the outset of the hearing, Dr Joshi, on behalf of the Nursing and Midwifery Council ("NMC"), made a request that parts of this hearing be held in private on the basis that proper exploration of this case involves reference to yours and Patient A's health and reference to family members. The application was made pursuant to Rule 19 of the

‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

On your behalf Ms Bayley indicated that she supported the application to the extent that any reference to your health, medical and family matters and Patient A’s health, medical and family matters should be heard in private.

Additionally, Ms Bayley made a separate application that any reference and details of the relationship between you and Patient A should also be heard in private. Dr Joshi opposed that application and submitted that the charges and crux of this case are intrinsically linked to the relationship between you and Patient A, and therefore should be in public.

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

The panel accepted the advice of the legal assessor and determined to go into private session when reference is made to health, medical and family matters of both Patient A and you. The panel further determined that references to personal and sexual relations between Patient A and you should be in public on the basis that these matters are intrinsic to the charges.

Oral evidence of Patient A as relates to public and private matters

On day 2 after completing the oral evidence of Patient A, the panel raised with the parties its intention to retrospectively mark the transcript into private for those health, medical and family matters. This was due to the fact that the nature of Patient A’s evidence was such that it had been inextricably intertwined between public and private and the hearing had not wished to unnecessarily interrupt a highly vulnerable witness.

Ms Bayley opposed this action by the panel on the basis that she had understood that all Patient A's evidence would be in private. Ms Bayley went on to say that at no point during Patient A's oral evidence did the hearing go into public session. Ms Bayley told the panel that while it is important the Patient A understood the difference between what is considered private and what is considered public, at this stage it does not make a material difference to the proceedings. She then proposed for the entirety of Patient A's evidence to be marked as private on the transcript but that the panel could use its judgement in employing the relevant evidence from Patient A's oral testimony, in its determination. Ms Bayley later conceded that Patient A had not been told that the entirety of his oral evidence would be heard in private.

In response, Dr Joshi told the panel that, as he understood it, Patient A had been advised in the pre-meeting that parts of his hearing would be in private if reference was made to his health, medical matters or his family and that anything else, would be public. This pre-meeting with Patient A, was held in the presence of Dr Joshi, Ms Bayley, the legal assessor and the hearings coordinator. It addressed matters such as how patient A wished to be addressed, the use of a privacy screen in the hearing to separate Patient A and you, and that the charges had been found proved. Dr Joshi agreed that it would have been difficult to separate Patient A's oral evidence in the hearing as it veered from private to public throughout.

The panel heard and accepted the advice of the legal assessor. He referred the panel to the NMC guidance *'Hearings in private and in public'* and reminded it that a panel can hear matters in private when it is satisfied that it is reasonable and proportionate to do so, and it is justified in the interests of any party, third party, or the public. Further, the panel was also reminded that Patient A was considered vulnerable due to his health. The legal assessor advised the panel that a practical way forward, might be that proposed by Ms Bayley.

The panel had regard to the submissions of Ms Bayley and Dr Joshi and found that, prior to giving evidence, Patient A had been advised that parts of the evidence that related to his health, medical and family matters would be in private. Patient A was also informed at the start of his oral evidence that the entirety of his witness statement would

be marked as private. The panel took account of the need to protect Patient A's vulnerability and the nature of his oral evidence being inextricably intertwined between private and public matters. The panel determined that, for reasons of practicality, his evidence would be marked as private on the transcript. Notwithstanding, the panel stood by its earlier decision that only matters relating to health, medical and family matters be in private. Accordingly, the panel would reflect this decision in its written determination. Further, the panel determined that matters relating to the personal and sexual relationship between you and Patient, would be in public in the determination.

Background

You were employed by Greater Manchester Mental Health NHS Foundation Trust ("the Trust") from 1990 to October 2019. You worked as a community psychiatry nurse with the North East community mental health team ("the CMHT") from 1999 to 2014.

You worked with Patient A from 1999 and were his Care Coordinator at the CMHT from 2006 until 2014 when he was discharged.

This is a misconduct case. The regulatory concerns arise out of two referrals: the first, a self-referral (20 May 2019) submitted by you and the second (3 June 2019) from the Associate Director of Nursing and Governance at the Trust.

Your 2019 self-referral disclosed that in 2011 you had a brief sexual relationship with '*an unnamed client*.' (Patient A). Your self-referral appears to have been prompted by Patient A's admission to the Trust's Accident & Emergency Department on 9 May 2019 following a suicide attempt whereby, when questioned as to why he had not been engaging with mental health services, he disclosed a previous sexual relationship with his Care Coordinator. The Nurse Practitioner who assessed Patient A subsequently completed a safeguarding referral which triggered the Trust's investigation.

The charges in this case involve:

- Breached professional boundaries in relation to your sexual relationship with a service user;
- Failure to disclose your sexual relationship with a service user to the Trust, and continuing to act as the service users care coordinator; and
- Dishonesty in that you intended to conceal your breach of professional boundaries from the Trust.

Decision and reasons on facts

At the outset of the hearing, the panel heard from Ms Bayley who informed the panel that you made full admissions to all of the charges.

The panel therefore found charges 1, 2 and 3 proved. In relation to charge 4, the panel found it proved in relation to dishonesty. The panel noted, as Ms Bayley informed the panel that you also accepted that you had failed to comply with your duty of candour.

Fitness to practise

Having found the facts proved, the panel then moved on to consider whether the facts found proved amounted to misconduct and, if so, whether your fitness to practise is currently impaired. There is no statutory definition of impairment of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

In its decision making, the panel took into account all of the documentary and oral evidence before it. This included the witness statements of:

Ms 1	Mental Health Nurse, Matron and Professional Lead Nurse, Greater Manchester Mental Health NHS Trust.
Ms 2	Nurse Practitioner, Mental Health Liaison, A&E at Manchester Royal Infirmary Department.

The panel also took into account the submissions made on behalf of the NMC and you.

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 exercised its own judgement.

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

In reaching its decision the panel was assisted by the oral evidence from Patient A, Ms 3, a character referee called on your behalf, and you. In relation to Patient A the panel noted, although Patient A had been warned and was available, Dr Joshi did not intend to call him to give evidence. However, the panel decided that it would be of assistance to hear oral evidence of Patient A.

Patient A's evidence

Patient A's witness statement was read out to him, and he confirmed its contents as being true and accurate to the best of his belief. In answer to questions, he confirmed that the sexual relationship between him and you, had started in the summer of 2011 and lasted for a number of months. He was adamant that he did not make any sexual advances towards you and had not started the sexual relationship. He told the panel that it had commenced after you had taken him to a hospital appointment and then driven him to near your home. You had gone together for a walk-in a nearby field and had been lying on the grass, turned to each other and the sexual relationship commenced *"it was like a couple of magnets."*

Patient A said that the sexual encounters had taken place at his home, his family member's home and your home. He said that they had taken place after hospital or home visits, including during your working hours. Patient A told the panel that family members were aware of what was taking place between him and you:

> *"…it was my [family member] said, "I know what's going on between you two because somebody like that would not go into your bedroom", yeah? If they come to see you, you go and sit in the back room or in the kitchen or in the garden, but he said, "You think I'm stupid, I know what you two have been up to…"*

Patient A also said that your neighbours had seen him with you in your garden.

Patient A also said that you had both discussed how the relationship was wrong and should not be taking place. He confirmed that the relationship had been rekindled at the end of October 2013.

Patient A explained that he thought that you had been distancing yourself from him [PRIVATE].

[PRIVATE]. Patient A said that you had both changed your personal phone numbers after this incident and exchanged them with each other again.

[PRIVATE]

Your evidence

In your oral evidence you maintained that Patient A did make sexual advances and started the sexual relationship with you. You agreed with his description of being like two '*magnets'* and confirmed that sexual relations had commenced in the field as described by Patient A. However, you told the panel that, prior to this, Patient A had

leaned toward you and kissed you in the car; you suggested that he may not remember this kiss.

You said that you had been looking after Patient A since 1999 and had become close. You accepted that, by the time that the sexual relationship started, you were fully aware that Patient A was vulnerable [PRIVATE].

[PRIVATE].

You said that you knew that what you were doing was wrong at the time. In response to questions from the panel as to why you did not escalate this matter to your colleagues or managers, you said *'…I was scared to make that first contact. I think it was just the fear of knowing that I'd lose my job and lose my home. And that was what – selfish priority was what guided me which was the wrong thing to do because I was putting his interests first, my standards first. And the professional standards that I used to have I didn't put them first…'*

You explained to the panel that you now realise that this was an untenable position and that you could not remain objective in your role as a nurse while engaging in a sexual relationship with Patient A. You apologised for the adverse impact of this upon Patient A. You had asked your representative to apologise to Patient A while he was giving his oral evidence.

[PRIVATE].

You confirmed that the relationship had ceased at the end of 2011 and that it had rekindled in December 2013, when you had had sexual relations with Patient A on two occasions.

[PRIVATE].

You said that Patient A and you both knew that the relationship was inappropriate and that you had discussed it at various points, that you had said *'…I just said, you know*

this can't happen, this can't continue. I would lose my job if -- well, already -- I already went too far, "I will lose my job", but maybe that was putting pressure on him wasn't it to kind of keep that secret then. Which I didn't ask him to keep it secret but by saying that I would lose my job, it kind of put him under pressure to ensure that I didn't lose my job, which was unfair to him. But he knew it anyway without me having to say that…'

You told the panel that this was also the reason that you had not declared your relationship to your employers. [PRIVATE]. You now understood that Patient A might not have disclosed the relationship because he did not want you to lose your job.

You said that you have spent the better part of the last two and a half years reflecting upon what you have done, why you did it and how you would prevent such a situation from occurring again. You confirmed that you have not been in touch with Patient A since he was discharged from specialist mental health services back to his GP unit in 2014.

You explained that you [PRIVATE] fully accept that what you did was wrong and that you were dishonest. You have now learned that you will always raise with your managers or colleagues any difficulties you may be experiencing in carrying out your professional nursing duties.

You said that it should not have taken Patient A to divulge the relationship for you to admit it. You said you had made huge mistakes and you said you appreciate the magnitude of the consequences and are prepared to do anything to remedy them. You said you accept whatever the outcome will be. You said that you had been totally unprofessional and just asked that what you have done since may be considered.

Submissions on misconduct and impairment

Dr Joshi invited the panel to take the view that your actions fell below what is expected of a registered nurse and that the facts found proved amount to misconduct. He referred the panel to the 'The code: Standards of conduct, performance and ethics for nurses and midwives 2008' ("the Code").

Dr Joshi reminded the panel that you accepted that your actions amount to misconduct and that you are impaired on public interest grounds. Dr Joshi then identified the specific standards where the NMC submits that your actions amounted to misconduct. Dr Joshi submitted that all the things that were happening were certainly within your control; that these were not accidental meetings. He submitted that your relationship with Patient A was contrived, planned and proceeded according to your needs. He submitted that your actions impacted Patient A who stated that he could not trust the mental health services and therefore how things had been ruined for him.

Dr Joshi submitted that your actions were serious and fell below the standards expected of a registered nurse.

Ms Bayley submitted that serious professional misconduct is accepted by you and that you recognise the parts of the Code that you have breached.

Dr Joshi 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Dr Joshi submitted that your conduct raised fundamental questions about trustworthiness, about lying and about covering up. He submitted that there were deep-seated attitudinal issues in your conduct, but that at no stage did you make any disclosure of any sort, even in the record, of some of the concerns that were obvious. Dr Joshi submitted that given the serious nature of your misconduct and the impact it had on Patient A you are currently impaired on both public protection and public interest grounds.

In relation to current impairment Ms Bayley provided the following written submissions, including the following:

‘Public Protection

17. The panel is invited to find, in light of the sincere remorse, remediation, insight, reflection, training and previous and subsequent good practice, that the risk of repetition of the misconduct is low. The Trust disciplinary and NMC proceedings have been a salutary experience, but nothing will compare with living with a true comprehension of the consequences of her actions.

18. Ms Fisher has clearly demonstrated a deep understanding of what she did wrong, why it was wrong and made changes to her practise to ensure the misconduct is not repeated. She has reflected at length on the impact of her actions on Patient A, his family, her other patients, her colleagues, the service, the service's patients, the Trust, the NHS and the wider community mental health and nursing professions. She has developed significant insight into the consequences of her actions, which the panel can be confident will never be repeated.

19. Having regard to all of the above, including the Cohen questions, and the guiding principle of proportionality, the panel is invited to find that Ms Fisher's fitness to practise is not currently impaired on public protection grounds.

Public Interest

20. It is agreed that, in light of the seriousness of the misconduct, the public interest requires a finding of impairment of fitness to practise, in order to declare and uphold proper professional standards of conduct and performance, to maintain public confidence in the profession and the NMC as a regulator.

Conclusion

21. The charges admitted and found proved by those admissions amount to serious professional misconduct. Ms Fisher's fitness to practise

is impaired on public interest grounds. The panel is invited to find however that on public protection grounds, Ms Fisher's fitness to practise is not impaired.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant principles including those set out in the case of *Grant*.

Resuming hearing

Having adjourned on day 7 of the hearing, the panel was due to resume in camera on 31 May 2022. However, in the circumstances where the transcripts of the hearing were not received by the panel within the expected time frame, the panel was unable to sit on this date. The panel agreed to further resuming dates in order to continue its deliberations. Therefore, the panel resumed in camera on 24 and 25 November 2022, after notice of the resumed hearing had been sent to you and your representative.

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

'1 You must treat people as individuals and respect their dignity…

7 You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising…

9 You must support people in caring for themselves to improve and maintain their health…

20 You must establish and actively maintain clear sexual boundaries at all times with people in your care, their families and carers…

21 You must keep your colleagues informed when you are sharing the care of others…

22 You must work with colleagues to monitor the quality of your work and maintain the safety of those in your care…

26 You must consult and take advice from colleagues when appropriate…

28 You must make a referral to another practitioner when it is in the best interests of someone in your care…

32 You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk…

33 You must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards…

Be open and honest, act with integrity and uphold the reputation of your profession…

Act with integrity…

51 You must inform any employers you work for if your fitness to practise is called into question…

54 You must act immediately to put matters right if someone in your care has suffered harm for any reason…

57 You must not abuse your privileged position for your own ends…

61 You must uphold the reputation of your profession at all times…'

The panel appreciated that all breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that your misconduct was sufficiently serious in that you engaged in a sexual relationship with a highly vulnerable patient and acted dishonestly by failing to disclose the relationship to the Trust. The panel was of the view your actions would be considered deplorable by fellow practitioners and members of the public. Further your actions put the reputation of the nursing profession in disrepute.

In these circumstances the panel found that your actions did fall significantly short of the conduct and standards expected of a registered nurse and were serious enough to amount to misconduct.

Decision and reasons on impairment

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

In deciding the issue of current impairment, the panel considered Dame Janet Smith's "test" set out in the case of *Grant* at paragraph 76:

'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'

In conjunction with the above "test", the panel also took into consideration the NMC's guidance on *'Serious concerns which are more difficult to put right.'* The panel was of the view that the following were particularly engaged in your case:

- *'breaching the professional duty of candour to be open and honest when things go wrong, including covering up…*

- *sexual … relationships with patients in breach of guidance on clear sexual boundaries…*

- *being directly responsible… for exposing patients or service users to harm… especially where the evidence shows the nurse, midwife or nursing associate putting their own priorities… before their professional duty to ensure patient safety and dignity…'*

In applying the guidance and the "test" from the case of *Grant*, the panel concluded that limbs (a), (b), (c) and (d) were engaged in this case in respect of your conduct found proved. Patient A was put at a risk of unwarranted harm as after your relationship had ended in 2013, [PRIVATE]. Further, the panel was of the view that your actions in having a sexual relationship with Patient A did bring the nursing profession into disrepute and breached several fundamental tenets of nursing. It further concluded that you acted dishonestly as you concealed the sexual relationship from the Trust and only

made a self-referral when the Trust came to learn of this after Patient A had disclosed the relationship to staff at the local Accident and Emergency department.

The panel then went on to consider whether you are liable to act in such a way in the future. In doing so, the panel assessed your level of insight and remediation, and had regard to your nursing practice both prior and subsequent to the matters found proved. Further, the panel had particular regard to the NMC's guidance on *'Can the concern be addressed?', 'Has the concern been addressed?'* and *'Is it highly unlikely that the conduct will be repeated?'*

The panel noted that when the concerns were first raised with you by the Trust, you did not disclose the facts of the matter; you attributed this to your initial shock and not having your union representative present. However, during the Trust disciplinary hearing, you told them '*everything that you remembered'*. The panel further took into account that, at the outset of this hearing, you also made full admissions and accepted the alternative part of charge 4, namely, that you had failed to comply with your duty of candour, albeit it that you were not required to do so as you had already admitted to the dishonesty part of charge 4.

The panel found no evidence of grooming or pre-meditation in your behaviour. While the panel accepted that inappropriate sexual relationships with vulnerable patients may not be possible to remedy, in the light of your high degree of remorse and insight, the panel was of the view that the misconduct in this case may be remediable.

The panel then went on to consider what steps you have taken in order to demonstrate your insight and remediation. The panel had careful regard to the self-directed research you had conducted into the importance of professional boundaries. This included reading and self-analysis relating to the following studies:

> *'An exploration of emotional protection and regulation in nurse-patient interactions: The role of the professional face and the emotional mirror…*
>
> *Boundary issues in Social Work: Managing Dual Relationships…*

Personal and work-related factors associated with nurse resilience…

Exploring Boundaries in the Nurse- Client Relationships: Professional Roles and Responsibilities…

A systematic review of stress and stress management interventions for mental health nurses…

Assertiveness among professional nurses…'

The panel took into account, that after having conducted your research, you scrutinised and applied your learning to your misconduct. It further noted that you had accepted and analysed how you breached the NMC's Code. You demonstrated through your critical evaluation of the research studies and the NMC's Code what you had learned, how this applied to your role as a registered nurse and how you would behave differently in the future.

The panel further noted that prior to the hearing, you had undertaken various online courses as related to your misconduct. These included training on lone working, the duty of candour, and dignity through action. In oral evidence, you explained that, although the duty of candour and dignity through action courses were 3 hours in duration, you had in reality spent some 8 hours on each course as you wanted to reflect by writing notes and embedding the principles into your practice.

Next, the panel took into account your reflective statements, including one using the *'Gibbs Reflective Cycle model'*. You indicated that your *'Reflection work commenced on 20.5.19. However, more intense reflection started from 20.6.19.'*

The panel noted the following extracts from your 2019 reflective statement, which was further elaborated upon in your oral evidence:

'…At the time I was, in a way flattered for the attention but confused as to why I was ignoring my professional boundaries and just allowing myself to get carried away in the moment and letting my heart rule my head. I always knew it was wrong and part of me yet struggled to understand why I ignored such loud voice telling me this.

[PRIVATE].

The panel was of the view that your statements gave a candid, in depth, and insightful account into the unique circumstances in which your misconduct took place.

'I think at the time of the relationship I lost my way professionally completely but since I've opened my eyes more and done a lot of soul searching…'

It then went on to note your reflection into how your actions impacted Patient A, which included:

'…What was bad was that I lost my way in my professional perspective and this effected our relationship. I told the [Patient A] that I couldn't continue and although he understood and expected this he didn't want to end it…

…I sincerely regret allowing this to happen, developing into a relationship and then not telling anyone about it. I know that by doing all these things I've let everyone down all these years – my profession, my clients, my colleagues, my seniors, the Trust, the NMC and the public as well as my family.

I can see now that by dealing with it early it could have been prevented and I could have learnt from the experience. [PRIVATE]'

Further, the panel noted that during your oral evidence, you had said:

[PRIVATE].

When assessing your insight and reflection into your actions on your colleagues, the panel noted:

> *'…I also hadn't considered how it would effect [sic] my colleagues if they'd have known or about keeping it secret for so long. I just put it away and tried to forget about it completely. I made a huge, huge mistake and was so ashamed that I didn't tell a soul, not even my closest friends and family…'*

When assessing how you would act if a similar situation were to arise in the future, you said in your oral evidence:

> *'…I would have done -- considered my plan of action, discussed it with my manager… And, you know, discussed a plan of action really how to speak to the client about it. I would have invited them back to the office, so it was a neutral facility and a more official facility rather than a home visit or my car. And just given him -- just opened the discussion about the blurring of boundaries, where that came from, from his point of view and his perspective of where the boundaries were blurred from my point of view…*
>
> *I should have spoke to my manager. I needed to step back, reflect, regroup, reprioritise and just be honest about all the stresses that I was going through. And disclose the relationship. I should have spoke to somebody… reflect on my code of conduct and the dignity and care principles that I value. I just needed to stop and think…When I did the dignity through action training recently that was really valuable. That stop, think, dignity, that was just a really simple statement that makes you -- that could have changed the whole course of events. But I think, you know, definitely clinical supervision. Just to explore what was happening. I needed to speak to somebody, whether it was a colleague, or the*

whistleblowing…speak to my union rep or a colleague or my manager and I didn't do that…'

In your written statement you addressed what you would do if you were faced with the same situation in the future:

'…Currently I work in a Care Home so the residents are elderly mostly and some have dementia. So dealing with any potential inappropriate behaviour can be challenging as they will forget what I've said.

However, in that instance when it has happened I have kept it simple and clear and then used distraction. This has been successful so far…

…I would talk to my deputy manager about it and discuss it in clinical supervision, even if it wasn't officially set up at the time...'

Assessing your self-directed research, online training courses, reflective statements and your oral evidence as a whole, the panel considered that you have made a comprehensive assessment of the steps you would take if you found yourself in a similar situation in the future. It noted that, prior to the referral made to the NMC, you had an unblemished record and that you are currently working as a registered nurse in a care home. The panel noted that, since your misconduct in 2011 and 2013, some nine years have elapsed, during which there have been no further referrals or concerns against you.

The panel also noted that you had *'asked to thank patient A for his time and again, apologise on* [your] *behalf that he's had to go through this after all this time, and also, to let him know that* [you] *are so sorry to have put you through all of this and for so long…'* It was of the view that this showed genuine remorse and an awareness of the impact of your actions upon Patient A.

The panel was also of the view that the extent of insight and remediation was supported by Ms 3, who attended the hearing to give evidence on your behalf. The panel noted the following in particular:

> *'…I am currently employed as CBT therapist in an IAPT service in Greater Manchester Mental Health NHS Trust. I have been an RMN since 1985. I have also been a union rep since 1982…*
>
> *I have known Paula Fisher since the 1990s when I was a colleague CPN of hers in the Community Mental Health Teams in North Manchester. I left this post in 2007…*
>
> *When I worked with Paula, she was one of the most conscientious and caring nurses I have ever worked with… I was extremely surprised when I found out what she had done, as it felt very out of character for the Paula I had worked with for many years.*
>
> *In May 2019, she rang me, as her union rep, to say she had been suspended from work following an allegation of an inappropriate sexual relationship with a client….*
>
> *She wanted to admit to the Trust too that it was true. She said that she did not want the client to be put in a position where he was not believed, as this would compound the problems and consequences for him…*
>
> *Paula tried to look at what she had done not just from her own perspective but from her clients too. [PRIVATE]*
>
> *She also realised her personal needs could not be separated from her nursing duties, however much she had tried to convince herself that she was able to separate them…*

Paula was committed to understanding the depth of consequences of her actions for the client, for other clients, for health colleagues, for the Trust….

Paula was committed to absolutely guaranteeing it would not happen again. Even though she was clear she would never act in this way again, she wanted to explore every possible protection she might put in place such as supervision, study on boundary conflicts and difficulties in nursing… [PRIVATE]'

The panel has considered, in according with the 'test' in Grant, its obligation to look not only at the past but also - so far as it can - to the future. Having done so and taking into account all of the above, the panel consider that you are not liable in the future to:

- Put patients at an unwarranted risk of harm
- Bring the profession into disrepute
- Breach fundamental tenets of the profession
- Act dishonestly

Therefore, the panel determined that a finding of impairment is not necessary on the grounds of public protection.

The panel next considered if a finding of impairment is necessary on the grounds of public interest.

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

The panel noted that the charges found proved by admission are serious and involve a sexual relationship with Patient A, whilst you continued to act as his care coordinator, in

breach of professional boundaries. You have also admitted dishonesty, relating to concealment from the Trust of your breach of professional boundaries. The panel considered that a well-informed member of the public would be shocked if such charges were not marked by the regulator and the public confidence in the profession would be undermined if a finding of impairment was not made in this case. The panel therefore finds your fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, in the panel's professional judgement, your fitness to practise is currently impaired on the ground of public interest alone.

Sanction

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

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

Submissions on sanction

Dr Joshi informed the panel that in the Notice of Hearing, dated 1 March 2022, the NMC had advised you and your representative that it would seek the imposition of a strike off order if it found your fitness to practise currently impaired.

Dr Joshi submitted that as the panel has found impairment relating to charges proved of historical sexual misconduct and dishonesty on public interest grounds, it must now consider how a member of the public would view the conduct found proved and the impact of your misconduct and current impairment on public confidence in the nursing profession.

Dr Joshi submitted that the following aggravating features should be considered as the panel deliberated the appropriate sanction:

- Length of time over which the sexual relationship occurred
- [PRIVATE]

Dr Joshi submitted that the breach of professional boundaries and dishonesty in this case is very serious. [PRIVATE]. Dr Joshi invited the panel to consider that as this evidence will be in the public domain it is necessary to consider the public interest in light of this.

Dr Joshi drew the panel's attention to the SG relating to dishonesty:

> *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*

He submitted that the above factors are engaged in this case. He submitted that there was a power imbalance between Patient A and you. [PRIVATE].

Dr Joshi next drew the panel's attention to the sexual misconduct SG and submitted that based on this guidance, the only appropriate sanction in this case is a striking off order. He told the panel that the guidance goes on to state that if a less severe sanction

than a strike off order is imposed, then the panel must explain very clearly and very carefully why it has chosen this course.

Dr Joshi finally addressed the panel regarding your insight. He drew the panel's attention to your most recent reflective piece dated 21-29 November 2022. He submitted that your reflection in relation to Patient A did not show full insight. He referred to the following statement which the NMC considered to be the concerning aspect:

> *'I do feel that much of his anger appeared to be based on his perceptions of what happened and the belief that I had motives which he felt was to use him and then leave him…*
>
> *…the additional perceptions, or rather what I would say are misperceptions that seem to have built up over the years.*
>
> *[PRIVATE]*

He submitted that by referring to Patient A's '*perceptions*', '*misperceptions*', and '*beliefs*' with regard to the relevant harm, you were not exhibiting full insight into your own culpability in the relationship with Patient A.

Dr Joshi invited the panel to consider that the only sufficient sanction in this case is a striking off order.

The panel next heard from Ms Bayley. The panel had her written submission before it and she highlighted the following paragraphs from it in her oral submissions:

> *'1.The panel is reminded that all charges were admitted at the outset of the hearing. There now findings of misconduct and current impairment, on public interest grounds. The panel is now tasked, in reality, with determining whether a sanction of temporary or permanent erasure is appropriate and proportionate in the case…*

4. …The question of what the public interest requires in any given case is a matter for the professional judgment of the panel. There is no agreed definition of what public confidence is, or what behaviours or regulatory action may impact upon it in the context of health professional regulation. The High Court has held that public confidence decision-making should "reflect the views of an informed and reasonable member of the public" appraised of all the circumstances of the case (Giele v GMC [2006] 1 WLR 942 at [33])….

26. …The NMC Guidance on Factors to Consider Before Deciding Sanctions, 29 November 2021, indicates that the following ought to be considered relevant aggravating factors:

> *"Some possible aggravating features are:*
> *- any previous regulatory or disciplinary findings [not applicable]*
> *- abuse of a position of trust [applicable in part]*
> *- lack of insight into failings [not applicable]*
> *- a pattern of misconduct over a period of time [applicable in part]*
> *- conduct which put patients at risk of suffering harm [applicable]"*

27. In addition to the mitigation discussed above, the following mitigating factors are also listed within the Guidance and are all relevant to the Panel's considerations:

> *"Mitigation can be considered in three categories.*
> *- Evidence of the nurse, midwife or nursing associate's insight and understanding of the problem, and their attempts to address it. This may include early admission of the facts, apologies to anyone affected, any efforts to prevent similar things happening again, or any efforts to put problems right.*
> *- Evidence that the nurse, midwife or nursing associate has followed the principles of good practice. This may include them showing they have kept up to date with their area of practice.*

- Personal mitigation, such as periods of stress or illness, personal and financial hardship, level of experience at the time in question, and the level of support in the workplace."'

Ms Bayley submitted, that Dr Joshi's submissions about your use of the words '*perception*', '*misperception*' and '*belief*' in your reflective piece, is not a grave concern and that you have not suggested that Patient A is lying. It does not detract from your insight, remorse, and that you accept that you failed to tell the Trust and failed to safeguard Patient A. Ms Bayley submitted that you had made an error in very difficult personal circumstances and that you had an otherwise unblemished career and were of good character.

Ms Bayley asked the panel to consider: what does a nurse do after the mistake? She submitted that you have done everything you could in that, you accept responsibility and misconduct, and while dishonesty is very difficult to remediate, you have worked to improve yourself as a nurse and a human being and that you have provided very positive testimonials. She also submitted that you accept that it is still early on in terms of your remediation and there is still more to be done and that these proceedings have served as a salutary lesson for you. She submitted that all of this goes toward satisfying the public interest in this case.

Ms Bayley concluded with the following from her written submissions:

29. In the very specific circumstances of this case, erasure is not the only proportionate sanction available to the panel, considering current impairment on public confidence grounds. A sanction of up to 12 months suspension is a severe sanction to impose on any practitioner. If a review were required, it would be for future panel to reassess Ms Fisher's fitness to practise and Ms Fisher would only be allowed to return to practise if and when an NMC panel deemed her fit to do so.

Ms Bayley submitted, that in this case, your reflection, supervision, and retraining all go toward the appropriateness of a suspension order to mark the public interest and allow

further time for reflection and remediation, after which a further panel could assess your progress and the issue of the public interest.

Decision and reasons on sanction

The panel accepted the advice of the legal assessor.

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

The panel took into account the following aggravating features:

- The misconduct only came to light some six to eight years after the events, [PRIVATE].
- Abuse of a position of trust, recognising the imbalance of power in the relationship between Patient A and you [PRIVATE]
- [PRIVATE]
- A pattern of misconduct over of two years [sexual misconduct] and eight years [dishonesty]
- [PRIVATE]
- The sexual relationship, on occasions, took place during your working hours

The panel also took into account the following mitigating features:

- At the outset of the hearing, you made full admissions to the charges and accepted misconduct and impairment on public interest grounds
- You have apologised and shown genuine remorse and awareness of your impact on Patient A and the nursing profession

- You have taken considerable steps to prevent similar things happening again
- Since your misconduct in 2011 and 2013, some nine years have elapsed, during which there have been no further referrals or concerns against you
- [PRIVATE]

The panel noted the range of testimonials before it. It noted that these were submitted before the panel's decision on impairment and misconduct and noted that none of the authors had seen the charges, but to, in varying degrees, were aware of the allegations against you. The panel placed particular weight on the testimonials from Treelands Care Home, which were on headed paper, dated and signed from your employers, and from persons who had a fuller understanding of the detail of the charges. Though none of the testimonials directly addressed your misconduct, all of the character references spoke to your care, compassion, and commitment to nursing.

The panel considered the following NMC guidance: Considering Sanctions for Serious Cases. It took into account within this guidance, Cases Involving Dishonesty and found that the following were engaged:

- 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
- patients as vulnerable victims
- direct risk to patients
- longstanding deception

In making its decision, it also had regard to the NMC guidance Cases Involving Sexual Misconduct and the Council for Healthcare Regulatory Excellence guidance on Clear Sexual Boundaries Between Healthcare Professionals and Patients and the Professional Authorities Guidance on How is Public Confidence Maintained When Fitness to Practise Decisions are Made.

The panel took into account that there have been no previous regulatory concerns against you.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the serious concerns 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 your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG regarding conditions of practice.

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, as conditions of practice would not be relevant to the charges found proved. Furthermore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case, nor is it proportionate to address the public interest.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The panel carefully considered whether a suspension order would be sufficient to address the public interest in this case. The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. In regard to this, the panel placed substantial weight on the aggravating features of your case, particularly the harm caused to Patient A. The panel regarded as significant your persistent dishonesty in not disclosing your sexual relationship [PRIVATE].

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction in order to address the public interest concerns, which include upholding standards and maintaining confidence in the profession and its regulator.

Finally, in considering a striking-off order, the panel took note of the following bullet points of the SG:

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

The panel considered each of these bullet points and determined that the regulatory concerns do raise fundamental questions about your professionalism. The panel was of the view that it would not be possible to maintain public confidence in nurses if you were not removed from the register. Even though the panel determined that there is not a risk of repetition in this case, it found that a striking-off order was the only sanction which would be sufficient to maintain professional standards due to the seriousness of charges found proved.

The panel determined that the serious breach of the fundamental tenets of the profession evidenced by your actions is fundamentally incompatible with you remaining on the register.

In reaching this decision, the panel acknowledged your full admissions to the charges, your genuine remorse and the considerable efforts you have made toward remediation. The panel also noted your significant degree of insight and indication that you would like to continue to develop this. The panel reminded itself that the finding of impairment was made on the grounds of public interest alone and that there were no concerns regarding your clinical competence. However, the panel considered the aggravating features and found that these, and the charges found proved, were so serious, in regard to both dishonesty and sexual misconduct that a striking off order is necessary to maintain trust and confidence in the profession. The panel was of the view that to allow you to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

This will be confirmed to you 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 your own interests 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 Dr Joshi. He submitted that an interim suspension order was necessary in light of the panel's decision to impose a striking off order, as this was otherwise in the public interest. He invited the panel to impose the order for 18 months to allow sufficient time for an appeal.

The panel also took into account the following written submissions from Ms Bayley:

> *'…Interim Order*
> *30. If Ms Fisher is temporarily or permanently removed from the Register, it is anticipated that the NMC will apply for an interim suspension order, to apply in the 28 day appeal period and in the event of an appeal. There is no objection to this course if removal is ordered. However, if the panel decides on a specific period of suspension, to mark the public interest, it would not be necessary to effectively elongate the specified period by 28 days. In those circumstances, the panel is invited to consider whether the high bar of necessity would be met in order to justify the imposition of an interim suspension order…'*

Decision and reasons on interim order

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

The panel was satisfied that an interim order is necessary as being otherwise in the public interest. The panel had regard to the advice of the legal assessor that there is a high bar to make an interim order on public interest grounds alone. The panel was

satisfied that the high bar was met in the specific circumstances of this case, taking in account its reasons and decision set out above to strike your name from the register.

The panel concluded that an interim conditions of practice order would not be relevant, 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 provide sufficient time, should an appeal be made.

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

That concludes this determination.