Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 5 June 2023 to Wednesday 14 June 2023
Monday 30 October 2023 – Tuesday 31 October 2023

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

Name of Registrant:	**Ishaq Ibrahim**
NMC PIN	11A0471E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing (29 March 2011)
Relevant Location:	London
Type of case:	Misconduct
Panel members:	Anthony Mole (Chair, Lay member) Pauline Esson (Registrant member) Tricia Breslin (Lay member)
Legal Assessor:	Justin Gau (5 – 14 June 2023) John Bromley-Davenport KC (30 – 31 October 2023)
Hearings Coordinator:	Petra Bernard (5 – 14 June 2023) Sophie Cubillo-Barsi (30 – 31 October 2023)
Nursing and Midwifery Council:	Represented by Ms Thornton, Case Presenter (5 – 14 June 2023) Assad Badruddin (30 – 31 October 2023)
Mr Ibrahim:	Present and represented by Ms Aparna Rao (of Counsel), instructed by the Royal College of Nurses (RCN)
No case to answer:	Charges 2a, 2b(ii)
Facts proved by admission:	Charge 1 (in part)
Facts proved:	Charges 1, 2b(i), 2c, 2d, 3a, 3b

Fitness to practise:	**Impaired**
Sanction:	**Conditions of practice order – 12 months**
Interim order:	**Interim conditions of practice order – 18 months**

Details of charge (as read)

"That you a registered nurse:

1) On 27 November 2017 to 28 November 2017 on one or more occasions prevented Patient A from leaving her room.

2) Your actions at charge 1 were:
a) Not supported by Patient A's care plan;

b) Contrary to the advice of:
- i. Colleague A;
- ii. Colleague B.

c) Unnecessarily caused distress to Patient A;

d) Continued despite you being aware of Patient A's distress.

3) In response to being questioned by colleagues relating to your actions in respect
of Patient A:

a) Raised your voice to Colleague A;

b) Raised your voice to Colleague C.

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 in private (Day three)

Ms Rao made a retrospective application on your behalf, prior to you giving evidence, that parts of your case be held in private on the basis that proper exploration of your case involves reference to your private family life. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Thornton did not object to this application.

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

The panel determined to go into private session in connection with your private family life as and when such issues are raised.

Decision and reasons on application to admit written statement as hearsay evidence (Day two)

The panel heard an application made by Ms Thornton under Rule 31 to allow the written statement of Colleague B to be admitted as hearsay testimony into evidence. Ms Thornton submitted that Colleague B was not present at this hearing. She submitted that NMC had made various efforts to ensure that this witness was present but to no avail. Colleague B has been non-responsive to all communications sent to him in relation to this hearing thus far, including repeated emails, telephone calls, text messages, and letters, including a reluctant witness letter dated 15 May 2023.

Ms Thornton told the panel that she had enquired with the reviewing lawyer of this case, why it was only yesterday, 6 June 2023, that Ms Rao had been informed that Colleague B was not attending the hearing to give oral evidence. Ms Thornton relayed the reviewing lawyers unreserved apologies that this information had not been circulated beforehand.

Ms Thornton submitted that the evidence in Colleague B's statement is relevant to the issue at hand in relation to the events of 27 November 2017. She submitted that Colleague B worked with Colleague A on the night in question and his statement gives an account as to what he witnessed on the night in relation to the one to one care of Patient A. Ms Thornton submitted that the contents are an account of the exchange that took place between you and Colleague B. She submitted that the evidence is relevant and it is not the sole and decisive evidence in this case and can be admitted at the discretion of the panel.

Ms Rao opposed the application. She submitted that Colleague B's evidence is highly relevant and she was hoping to question him on a number of matters. She submitted that the problem here is fairness because the default position is that the registrant should see, hear and cross-examine anyone making allegations against him.

Ms Rao referred to the chronology of attempts to contact Colleague B. Ms Rao submitted that Colleague B's motivation and willingness to cooperate has to be questioned. Further, she noted that Colleague B's witness statement was signed almost two years after the incident had occurred, with no indication that he has had access to Patient A's notes or reference to anything else other than it was written to the best of his recollection. Ms Rao submitted that it is unfair to admit Colleague B's evidence as we do not know how accurate Colleague B's recollection may have been in the intervening time, and contrary to what Ms Thornton has said, Colleague B's evidence is the sole evidence in relation to charge 2a(ii). She submitted that there is no other evidence to show that Colleague B gave the alleged advice to you. Ms Rao noted that when Colleague A was asked about this it is to be noted that she could not remember.

Ms Rao submitted that were Colleague B's evidence to be admitted, it could not be relied upon. However, she noted that the panel are entitled to take into account the usefulness of the evidence once weight is applied to it. Nevertheless, Ms Rao submitted that it offers very little weight, and there is no corroborative evidence about the timing and duration as to what happened on the night, Further, Colleague B's evidence is very different from yours as he is not in attendance he cannot be questioned and cross-examined about it.

Ms Rao submitted that the absence of a good and cogent reason is that it is a good indicator that it would not be fair. She submitted that Colleague B has been out of contact with the NMC for over 18 months with no significant progress with communication over two years. She submitted that there is no indication that the NMC have turned their minds properly to the issue of Colleague B's attendance, noting that it was not in the reviewing lawyer's purview until (5 June 2023). She submitted that we do not know why he cannot attend and has not been provided any reason why he has not attended the hearing to give evidence. She submitted that it appears that the basic efforts have not been undertaken by the NMC to secure his attendance.

Ms Rao invited the panel to not admit Colleague B's witness statement and corresponding exhibits into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. He also referred the panel to relevant case law, which included *Bonhoeffer V GMC* [2011] EWHC 1585 (Admin) and *Thorneycroft v NMC* [2014] EWHC 1565 (Admin).

The panel gave the application in regard to Colleague B serious consideration. The panel noted that Colleague B's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, '*This statement … is true to the best of my information, knowledge and belief*' and signed by him.

The panel considered whether you would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Colleague B to allowing hearsay testimony into evidence.

The panel considered that as you had been provided with a copy of Colleague B's statement and, as the panel determined that he had chosen voluntarily to absent himself from these proceedings, you would not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Colleague B and the opportunity of questioning and probing that testimony.

The panel noted that it has not been provided with any cogent reason as to why Colleague B has not attended to give oral evidence. However, the panel came to the view that it would be fair and relevant to admit into evidence the written statement of Colleague B into hearsay evidence, but would give what it deemed appropriate weight once the panel had heard and evaluated all the other evidence before it.

Decision and reasons on application of no case to answer (Day three)

The panel considered an application from Ms Rao that there is no case to answer in respect of charges 2a and 2b(ii). This application was made under Rule 24(7). The Rule states:

'24 *(7) Except where all the facts have been admitted and found proved under paragraph (5), at the close of the Council's case, and –*

(i) either upon the application of the registrant …

the Committee may hear submissions from the parties as to whether sufficient evidence has been presented to find the facts proved and shall make a determination as to whether the registrant has a case to answer.

In relation to this application*,* Ms Rao made both written and oral submissions, a summary of which follows. She referred the panel to the NMC Fitness to Practise Rules 2004, Rule 24(7) and also cited relevant case law, including: the applicable test as set out in *R v Galbraith [1981]* 1 WLR 1039; *R (Sharaf) v. General Medical Council* [2013] EWHC 3332 (Admin); *Soni v. General Medical Council* [2015] EWHC 364 (Admin); *(Professional Standards Authority for Health and Social Care v. NMC and X* [2018] EWHC 70 (Admin); *R (Wheeler) v Assistant Commissioner House of the Metropolitan Police* [2008] EWHC 349; *R (Bonhoeffer) v. General Medical Council* [2011] EWHC 1585 (Admin) and *Thorneycroft v. Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

In relation to charge 2(a) she submitted that this charge alleges that the actions at charge 1 were *"not supported by Patient A's care plan*". The NMC has not produced in evidence any care plan for Patient A. The evidence of the live witnesses whose evidence was tested in cross-examination was as follows:

a. [Colleague C] stated in cross-examination that *"there was no care plan at all, just what is in the clinical notes."* She stated that *"there was no mental health care plan."*

b. [Colleague A] stated in cross-examination that "there was no written care plan or summary of the care the patient required". Her view was that the care plan was communicated orally from nurse to nurse at handovers. She suggested that reading the whole of the patient's notes would give an idea of the care required. She agreed that this was not a realistic task for Mr Ibrahim to have undertaken, and suggested that he should have read the last 48 hours of notes for the patient.

    Ms Rao respectfully submitted that the only fair conclusion is that there was no care plan, and consequently this charge should fail under limb one of *Galbraith.*

In the alternative, Ms Rao submitted that if it were to be considered that some amorphous form of care plan did exist as an end-product of the collected notes and

records of the patient, it plainly was inconsistent with the care plan that Colleague A conveyed orally to you. She submitted that evidence therefore falls foul of limb two of *Galbraith*.

Ms Rao told the panel that scrutiny of the medical and Deprivation of Liberty Safeguards (DoLS) notes made available to the panel by the NMC shows that the patient had been on 2:1 constant special observation for her own safety (increasing risk of falls and absconding) for the entirety of her care until 27 November 2017. Any *'verbal-only care plan'* conveyed to Mr Ibrahim was necessarily based on the premise that the patient was subject to a 2:1 care restriction. It is clear from Colleague C's evidence that when the care was reduced to 1:1, no adjustment was made to the 'verbal-only care plan' that Colleague C and Colleague A wished you to follow. No risk assessment, documentation, or procedure was followed and the reduction was not supported by the patient's care history and the DOLS assessment. In those circumstances, she submitted that it could not be said that your actions when undertaking 1:1 care on the night of 27-28 November 2017 were *"not supported by"* a *'verbal-only care plan'* which had specifically been formulated for 2:1 care.

She submitted that the NMC's evidence as to the parameters of any care plan is so weak, vague, and inconsistent that a properly directed panel could not find charge 2(a) proved pursuant to limb two of *Galbraith*. She submitted that it would be unfair to expect you to answer this charge.

In relation to charge 2(b)(ii) Ms Rao submitted that this charge relies solely upon an allegation made by Colleague B in a witness statement admitted as hearsay evidence. She submitted that there is no other evidence that makes out this charge and that the email at from Colleague C dated 20 December 2017 is merely a shorter, less detailed, outline of his witness statement.

Ms Rao submitted that Colleague B has not given live evidence to the panel and has not submitted himself for cross-examination. She submitted that the reason for this is not known and there has been no opportunity for the panel to test the truth of his allegation, whether he did give advice to you, what that advice was (if any), why he

gave it, and why he nonetheless deferred to your judgment. She submitted that Colleague B's witness statement is some two years after the incident and appears to have been made without reference to the medical notes. She submitted that the panel has not had an opportunity to hear whether Colleague B's advice would have been different had he recognised that a care reduction had just taken place. Ms Rao submitted that it would be unfair to expect you to answer this charge in these circumstances. She submitted that to ask you to answer this hearsay assertion without having had the opportunity to test it is to seek from him admissions to make out the NMC's case which is not his task to do. She submitted that the NMC must by itself establish that there is a case to answer. She submitted that insofar as there is any evidence supporting this charge, that evidence falls squarely into limb two of *Galbraith*.

Ms Rao submitted that taking the evidence at its highest, (1) there is either no evidence, or (2) it would be unsafe to find these charges proved and a properly directed Panel could not properly do so. It should be remembered that the NMC brings this case and bears the burden of proof. Further, the NMC chooses what allegations to charge, and has the means, time, and powers to obtain the proper evidence to support those charges. Charges which it cannot prove by reliance on its own evidence may not be used as a device to elicit admissions from the accused.

Ms Rao respectfully invited the panel to find that charges 2(a) and 2(b)(ii) are not proved pursuant to Rule 24(7) and further, she submitted that these charges should not be allowed to remain before the panel.

Ms Thornton submitted on behalf of the NMC, that there is sufficient evidence such that, taken at its highest, the panel could find 2(a) and 2(b)(ii) charges proved. She submitted that there is a case to answer and that there is clear evidence given by Colleague C and Colleague A to show that a care plan or a care plan existed. She submitted that there is some evidence upon which the panel can make a finding.

Ms Thornton concluded that the responses given by the NMC's witnesses to questions put to them during cross-examination were part of the NMC's case and evidence for the

panel to consider. In these circumstances, she submitted that these charges should be allowed to remain before the panel.

The panel heard and accepted the advice of the legal assessor who drew the panel's attention to the *"scintilla of evidence"* test identified in the civil case of case of *Benham Ltd v Kythira investments Ltd* [2003] EWCA Civ 1794 and the *"no case to answer"* test as set out in the case of *Galbraith.*

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether you had a case to answer. The panel applied the two limb test, set out in the case of *Galbraith*, which can be summarised as follows:

1. If there is no evidence against you to support a particular charge then the case must be stopped in respect of that particular charge.

2. If there is tenuous evidence in that it is inherently weak or vague or inconsistent with other evidence and if the panel considers taking the NMC evidence at its highest that it could not properly find the particular charge to be proved on the balance of probabilities then the case must be stopped as far as that particular charge is concerned. However, where the NMC's evidence is such that its strength or weakness depends on the view to be taken on a witnesses reliability, or other matters which are generally speaking within the province of the panel, as judges of the facts, where on one possible view of the facts there is evidence on which the panel could properly come to the conclusion that a particular charge is proved, then the case should proceed.

The panel considered whether there was evidence in respect of the charges it was due to consider for this application. Therefore, its assessment of this application fell under the second limb of *Galbraith*. It considered whether the evidence in respect of each of the charges under this application was sufficient in order find a case to answer.

Charge 2(a)

The panel took account of the oral evidence of Colleague A who told the panel that they did not do written care plans in the T13N haematology unit at the Hospital at the relevant time. The panel considered this to be a strong contextual point, however it took account of the document in the NMC exhibits bundle purported to be a form of a care plan, described by Colleague A as a floating document given during handover. The panel also noted that NMC witnesses have accepted that there is not a written care plan in existence and that this floating document was not relied upon by the NMC as the care plan.

The panel was of the view that there is no evidence of a written care plan for Patient A. Further, it noted that Colleague C in her oral evidence testified that there was no care plan for Patient A.

The panel was of the view that the document referred to as a care plan was merely a help sheet in relation to Patient A's care. Further, it considered that a care plan has to be a written document in the patient's medical notes where colleagues and nurses could see what the general care and specific care is for a patient. The panel considered that the while the floating document within the NMC exhibits bundle was useful for nurses during handovers, however it has no date, no author, no distinguishable signature or if you even had sight of this document at the time.

The panel noted that the NMC witness had conceded that there is no care plan in existence. The panel therefore considered that the evidence was insufficient to determine a case to answer in respect of charge 2a.

The panel determined therefore, that there is no case to answer in respect of Charge 2a.

Charge 2b(ii)

The panel considered whether there was an expression of opinion or direct advice given by Colleague B to you, for example, '*you must let her walk the corridor*'.

The panel took account that Colleague B was the nurse in charge on the shift and in his written statement in evidence, stated that he:

> *'...explained that it was good to let her walk around the corridors when she was agitated. I made it clear that we allowed her to do that and it seemed to calm her down...I again explained that this had never been an issue in the past, but he refused to let you out throughout the night shift' .*
> *'*

The panel determined that Colleague B expressed his concern to you however it cannot be described as *'advice'* in relation to Patient A.

The panel considered the email from Colleague B dated 20 December 2017 to Colleague C in which he expressed concern in relation to you keeping Patient A in her room with door closed while she was knocking on the door to be let out. The panel was of the view that it could not identify any specific advice given by Colleague B to you either expressly or otherwise. It determined that Colleague B's evidence in relation to this charge was weak, vague and tenuous for it to find a case to answer in respect of this charge.

The panel determined that there is no case to answer for Charge 2b(ii).

Minor amendment to the wording order in charge 2, 2c and 2d (Day five)

On day five on the hearing, it was brought to the panel's attention by the legal assessor that for grammatical purposes, the word '*were'* should be removed from the stem of charge 2 and placed at the beginning of charge 2b, as follows:

2) Your actions at charge 1 ~~were~~:

> ~~a) Not supported by Patient A's care plan;~~
>
> b) **Were** contrary to the advice of:
>
> > i. Colleague A;

~~ii. Colleague B.~~

c) Unnecessarily caused distress to Patient A;

d) Continued despite you being aware of Patient A's distress.

The NMC and Ms Rao did not object to the charge as amended.

The panel were of the view that there being no material change to the substance of the charges as amended, it determined to include the amendment and arrangement of the wording of the charges.

Closing submissions on facts

Ms Thornton and Ms Roa both prepared their respective written closing submissions on facts and they also made oral submissions of the same.

Background

The charges arose whilst you were employed by Day Webster working as an agency mental health registered nurse, on the Haematology Ward ('the Ward') at University College London Hospitals NHS Foundation Trust ('the Trust'). On evening of 27 November 2017 and the morning of 28 November 2017.

You had 1:1 care of Patient A. Patient A had CNS lymphoma, suffered from paranoid schizophrenia and was on a palliative care pathway. The NMC witnesses described her as five foot four inches, frail to the point of malnourishment and moved with a shuffling gait. When she became agitated, because she could not articulate her concerns, the ward practice was to allow her to walk at her liberty around the ward which de-escalated her behaviour. The NMC witnesses stated that her behaviour on that evening was no different from her usual behaviour and she was not an aggressive person. On the day shift of 27 November 2017, this was the first shift that Patient A was subject to 1:1 care, prior to that she was always subject to 2:1 care with an RMN and an Health Care

Assistant (HCA) caring for her. The NMC witnesses stated that they had informed you of the ward practice in allowing her to walk around the ward unrestricted.

In the early hours of 28 November 2017, Colleague A saw that you had closed Patient A in her room and you were holding the door closed. Patient A was plainly distressed, knocking on the door to be let out. Colleague A claimed that she told you *'you can't do that'* and that Patient A should be allowed to pace around the corridors. You apparently stopped holding the door closed at that point. When she returned from her break Colleague A claimed that she saw that you had shut Patient A back in her room and she could see and hear that Patient A was distressed. Colleague A claimed that she told you that Patient A should not be locked in her room. Your response apparently was that this is how you worked as a mental health nurse. In the morning, Colleague A made a complaint to Colleague C about your behaviour and included a note in the patient's notes. It is alleged that you raised your voice to both Colleague A and Colleague C when you were confronted with this.

Your case was that this patient was five foot eleven and not frail but slim. She was a falls risk due to the way she walked and the fact that she spilt liquids whilst walking on the ward. At times she would inadvertently walk into other patient's bays and distressed them. She was extremely difficult to deal with alone. She should have received 2:1 care still. At one point whilst you were caring for her, she ran towards the exit. At other points while she paced the corridors she was spilling milk down herself and on the floor as she had difficulty swallowing. When she was taken back to her room, she threw a pot of yoghurt towards you and you feared she was going to attack you. It was your opinion as a RMN, that the best treatment was to restrain her in her room by holding the door closed. You claimed that this was appropriate in all the circumstances.

The regulatory concern identified is:

- Failure to provide appropriate care to a vulnerable patient by depriving her of her liberty

Decision and reasons on facts

At the outset of the hearing on day one, the panel heard from Ms Rao, your representative, who informed the panel that you made a limited admission in part to charge 1, to the extent that you prevented Patient A from leaving her room between 3:00 – 4:00 am for one or two minutes in totality.

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

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

The panel heard oral evidence from the following witnesses under affirmation called on behalf of the NMC:

- Colleague C (heard remotely): Ward Manager / Ward Sister – Haematology T13N ward at the Hospital and the referrer, at the relevant time

- Colleague A (heard remotely): Registered Nurse - Haematology T13N ward at the Hospital, at the relevant time

The panel heard oral evidence from the following witness under oath called on your behalf:

- Witness 1: Registered mental health nurse - Haematology T13N ward on the

day shift on 27 November 2017 at the Hospital, at the relevant time

Prior to Witness 1 giving evidence, Ms Rao took her through several amendments and corrections to her written witness statement. These changes were read out, the statement amended and adopted into evidence as her evidence in chief.

Ms Thornton raised no objections to the amendments.

- Witness 2 — Registered mental health nurse – character referee

On Day 5 of the hearing, Witness 2 was due to give oral evidence as your character witness. Witness 2 was unable to appear in person at the hearing as arranged. Ms Rao requested that arrangements be made for Witness 2 to give his evidence remotely. Unfortunately, Witness 2 could not connect to the Microsoft Teams video link in order to appear visually on screen before the panel.

Ms Rao made a request that the panel allow Witness 2 to give his evidence exceptionally via audio only telephone via Microsoft Teams. Unfortunately, Microsoft Teams could not transcribe the telephone call

Ms Thornton withdrew her objections to this witness evidence being read.

In all the circumstances and on the basis that all parties were in agreement, the panel agreed to Ms Rao's request.

The panel also heard oral evidence from you under affirmation.

The panel heard and accepted the advice of the legal assessor, in particular that the panel should give no weight to Colleague B's written statement of evidence, unless any of the evidence had been adopted by you in your oral evidence.

Before making any findings on the facts the panel considered the witness and documentary evidence provided by both the NMC and you. The panel then considered each of the disputed charges and made the following findings.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Rao.

Charge 1

That you a registered nurse:

> 1) On 27 November 2017 to 28 November 2017 on one or more occasions prevented Patient A from leaving her room.

This charge is found proved

At the outset of the hearing on day one, the panel heard from your representative Ms Rao, who informed the panel that you made a limited admission in part to charge 1, to the extent that you prevented Patient A from leaving her room between 3:00 am to 4:00 am for one to two minutes in totality.

The panel also took into account the oral and written evidence of Colleague A.

The panel considered that Colleague A gave a clear account of the timeline before and after she returned from her two hour break. The panel found her evidence persuasive when she told the panel that she spoke to you once before her break some time before 2:00am. The panel took account that you stated that the incident happened at 2:45am however it accepted that this incident occurred six years ago and therefore your recollection of the precise time may not be as accurate as it may be given the intervening passage of time.

The panel took account of Colleague A's oral evidence and written statement when she saw you hold the door shut whilst Patient A was inside her room on two occasions.

Colleague A stated that the first time you did it you did stop when asked by her, however, when she returned from her break approximately two hours later, she observed you holding the door shut on Patient A whilst she was in her room again. On both occasions Colleague A told the panel that Patient A was distressed and could not verbalise how she felt.

The panel took account of Colleague C's email dated 1 December 2017 where she reported the incident to your employer. Further it noted Colleague A's clinical notes of 28 November 2017 at 7:45am wherein she states that she had a conversation with you several times during the shift about keeping Patient A in her room and that other nurses had also spoken to you about the same issue. The panel also noted that Colleague C had described Colleague A as being distressed when she reported the incident. The panel noted that both these written reports were much closer to the time of the incident.

The panel reject your evidence where you stated that you held the door on one occasion for one to two minutes and accepted Colleague A's evidence where she stated it occurred on two separate occasions.

The panel took account that you have admitted this charge in part however Colleague A's evidence was clear in relation to the number of times she witnessed the incident. The panel found Colleague A to be consistent in both her oral and written statement. The panel determined that it preferred the evidence of Colleague A in relation to the number of times you prevented Patient A from leaving her room and that it occurred on more than one occasion around the time of her first break and then after her break. Colleague A saw you holding the door and had said to you *'we don't do that'*, however when she returned from her break some two hours later, she witnessed your behaviour again with Patient A tapping on the door to be let out and looking distressed.

The panel noted in Colleague A's written statement, which states:

> *'when I came back from break he was holding the door closed with his hand again the patient was stood at the door tapping on the window she was distressed and couldn't verbalise what she felt but was not aggressive'*

The panel therefore determined that this charge is found proved in its entirety.

Charge 2a

2) Your actions at charge 1 were:

a) Not supported by Patient A's care plan;

No case to answer.

Charge 2b(i)

That you a registered nurse:

> 2) Your actions at charge 1:
> b) Were contrary to the advice of:
> > i. Colleague A;

This charge is found proved.

In reaching this decision, the panel took into account Colleague A's oral evidence and written statement. The panel accepted that Colleague A spoke to you directly and told you when you prevented Patient A from leaving her room, "*we don't do that"* upon observing you hold Patient A's door shut and not letting her out of her room. The panel considered that information was passed to you orally in relation to how Patient A was allowed to walk around and how nursing staff had managed her on the ward.

The panel had regard to Colleague A's written statement, in which she states:

> *'when Patient A was being held in her room, I clearly told [you], without raising my voice "you cant do that". He stopped for a little while...'*

The panel was of the view that your actions were contrary to advice given to you orally by Colleague A and further, your actions were also contrary to the National Institute for Health and Care Excellence's (NICE) guideline on restraining patients. The panel also took account that your witness, Witness 1, told the panel in her oral evidence that if she were faced with the same scenario as you described, she would not hold the door shut.

The panel rejected your evidence that Colleague A had never spoken to you about this and that neither she nor anyone else had been present when you held the door closed.

On the basis of the evidence put before it, the panel therefore determined that this charge is found proved.

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Charge 2b(ii)

That you a registered nurse:

2) Your actions at charge 1:
b) Were contrary to the advice of:
ii. Colleague B.

No case to answer.

Charge 2c

That you a registered nurse:

2) Your actions at charge 1:
c) Unnecessarily caused distress to Patient A;

This charge is found proved.

In reaching this decision, the panel took account of Colleague A's oral evidence and written witness statement.

The panel considered whether Patient A was distressed during the time she was detained in her room. In your own evidence, you stated that Patient A had said ‘*let me out’* and other witnesses stated that she was tapping on the door that you held shut. Further, the panel considered that Witness A heard and saw the incident take place and felt that she had to enter Patient A’s room to calm her down. The panel were of the view that both Colleague A’s oral and written evidence were consistent on this point. Further, the panel had regard to Colleague A’s patient notes as exhibited in evidence, and noted that she had written:

> *‘suggested to RMN it was best to not keep her in her room as her behaviour was getting increasingly worse, Patient A was crying and knocking on the door, eventually retired to sleep for approximately 15 mins...’.*

Colleague A said that this was the second occasion you were doing this and that Patient A was distressed. She said when she came back from her break she told you ‘*you cannot do that...that’s not what we do here’.* She told the panel that Patient A’s room was in plain sight from the corridor. At the end of her shift, she immediately escalated the incident to her line manager, Colleague C.

The panel were of the view that on a number of occasions Colleague A advised you of the recommended care for Patient A, in that she was allowed to walk up and down the ward. You said in your oral evidence that you were fearful, and had yogurt thrown at you, however the panel noted that you made no mention of it in your notes nor raised it with anyone at the time or at the end of your shift. The panel determined that there has not been any objective contemporaneous evidence at the time to show that it was necessary to prevent Patient A leaving her room in the way that you did, which caused her distress.

The panel accept that Patient A displayed challenging behaviour and required constant care and vigilance. The panel noted that Ms Rao in her submission stated that there is nothing to say how you should have dealt with this situation. However the panel determined that you should have reported the incident to your manager and colleagues

or a senior manager and recorded this in your notes along with the fact that you were fearful for your own safety. The panel accepted the evidence of Witness 1, who said in those circumstances you described, she would have pulled the alarm bell and shouted for help. As a last resort she stated that she would run away.

The panel determined that this charge is found proved.

Charge 2d

That you a registered nurse:

2) Your actions at charge 1:
d) Were continued despite you being aware of Patient A's distress.

This charge is found proved.

In reaching this decision, the panel determined that all the facts found proved in Charge 2c above, apply to this charge. The panel have accepted the evidence of Colleague A and have determined that you continued your actions which caused Patient A distress.

Charge 3a

That you a registered nurse:

3) In response to being questioned by colleagues relating to your actions in respect
of Patient A:

a) Raised your voice to Colleague A;

This charge is found proved.

In reaching this decision, the panel took into account the oral evidence and written statement of Colleague A and your own oral evidence.

The panel noted in your own oral evidence you stated that you may have raised your voice to get your point across. The panel accepted the evidence of Colleague A in her oral evidence where she stated '*...I disagree that he was not shouting'.*

The panel had regard to Colleague A's written statement in which she states that you approached her on the way to Colleague C's office and raised your voice saying '*YOU DIDN'T TELL ME WHAT I WAS DOING WAS WRONG'*(emphasis as per statement). The panel considered that this was confrontational.

The panel noted Ms Rao's submissions in relation to your demeanour, manner of speaking, your accent and your use of the English language whilst you were giving evidence. She raised the point that you spoke in your normal voice in a normal manner. In your own oral evidence you stated, '*I was alarmed, I spoke to her in my usual voice, equally she raised her voice as well'.* The panel noted that in cross-examination you said that it is quite possible that you raised your voice to emphasise your point. You said most people in this situation would raise their voice.

The panel determined on the balance of probability that this charge is found proved.

Charge 3b

That you a registered nurse:

> 3) In response to being questioned by colleagues relating to your actions in respect
> of Patient A:
>
> b) Raised your voice to Colleague C.

This charge is found proved.

In reaching this decision, the panel took into account of the oral evidence and witness statements of Colleague C and Colleague A. The panel noted that Colleague C stated that she raised her voice to ask you to leave and that you said in oral evidence '*It's quite possible I would argue my point...if I raise my voice to express my point but not in anger, but quite possibly I did'.*

The panel rejected your evidence when you said you went to the ward manager to report the incident. The panel determined that there has been no evidence or documentation to put before it to show that you reported the incident to the site manager on duty.

The panel were of the view that you raised your voice to justify and defend your professional position because you knew you did something wrong.

The panel determined that this charge is found proved.

Fitness to practise

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

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

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

Submissions on misconduct and impairment

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.'*

Ms Thornton 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.

Ms Thornton identified the specific, relevant standards where your actions amounted to misconduct. She then directed the panel to specific standards and identified where, in the NMC's view, your actions amounted to a breach of those standards.

Ms Thornton submitted that your behaviour over the incidents of 27 November 2017 and 28 November 2017 suggest that there are some underlying issues but more importantly your conduct is plainly serious in nature. She submitted that the primary duty of care was to act with patience and kindness towards Patient A. Ms Thornton submitted that your behaviour toward Patient A was compounded by her mental health illness which resulted in her having some impairment in her communication. Ms Thornton told the panel that Patient A had undergone acute surgery prior to her being placed under a DoLs.

Ms Thornton submitted that your conduct is serious in that you failed to provide care with compassion to a vulnerable patient and deprived her of her liberty in a hospital setting.

She submitted that Patient A and her family would be under the assumption that she would be treated with care and dignity by a professional who would essentially have the experience to deal with the difficulties she presented with at the time.

Ms Thornton submitted that, in this case, Patient A was a patient who had psychological difficulties and, in the circumstances. although her behaviour was challenging, she was still entitled to be treated with dignity and respect. She submitted that Patient A had been deprived of her liberty at times and she had an awareness of what was going on, and the impact it was having on her. She submitted that Patient A's distress was clear and evident in how she tried to communicate with you by banging on her room door to be let out and it was clear she did not approve in being detained in this manner. Despite this, you continued with this course of conduct, despite being told orally to stop, your behaviour persisted.

The NMC say that the deprivation of Patient A's liberty was unreasonable at the time. Ms Thornton submitted that there were other ways of caring for this patient.

Ms Thornton submitted that there is clearly concern in relation to your lack of acceptance of advice that was imparted to you at the time by clinical staff who were acquainted with Patient A's care on the ward, although not in a mental health capacity. She submitted that this demonstrates that your attitude towards Patient A was oppressive in the circumstance and you were resistant to advice at the time to stop the action in question which was keeping the door shut and keeping her confined in her room.

Ms Thornton submitted that the level of care involved in this care is a departure from the standards expected of a registered nurse in this given situation and it caused significant distress to the patient. She submitted that these failings if repeated are likely to cause a risk to patients in the future if they are not remedied. She submitted that, more importantly, upholding the dignity of patients is fundamentally important as well as respect and compassion.

Ms Thornton then 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. Ms Thornton referred the panel to the NMC Code case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin). She submitted that limbs a, b, and c of Dame Janet Smith's test, as set out in the Fifth Report from Shipman, were engaged in this case, as follows:

> *'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 to bring the [nursing] 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 [nursing] profession;*
>
> ...'

Ms Thornton submitted that you have provided representations in the impairment bundle, and although there is reflection, you do not recognise the distress caused to Patient A. She invited the panel to have regard to all the evidence in this case and also to take account of all the regulatory concerns, including failure to give appropriate care in a dignified manner and failure to escalate the care priority and need for support. She submitted that your conduct occurred over a period of time and on 27 and 28 November 2017 and there were at least two occasions when Patient A was in an environment of fear and distress where her wishes were disrespected. In addition, Patient A's mental wellbeing may well have been impacted due to what she experienced.

Ms Thornton invited the panel to make a finding of current impairment on public protection and public interest grounds.

Ms Rao referred the panel to the case of *Bar Standards Board v Howd* [2017] EWHC 210 (Admin) and of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a *"word of general effect, involving some act or omission which falls short of what would be proper in the circumstances... It is not any professional misconduct which will qualify. The professional misconduct must be serious.".* She submitted that misconduct in this case does not meet the high threshold of *Roylance.* Ms Rao submitted that this is one incident over a night shift. She submitted that you were otherwise performing your job without complaint, without difficulty and without error. Ms Rao reminded the panel that the key factor which it must consider is whether any misconduct is serious.

Ms Rao submitted that she accepted the panel's findings and that provisions of the Code may have been breached and there may well be misconduct. However, she submitted that if we look at the situation you were in there were no suggestions of malice or wilful infliction of pain and distress on Patient A. She submitted that it was a misjudgement on your part of how to deal with a difficult and challenging patient. She submitted that the panel now need to decide if your handling of the situation was so bad that it fell significantly short of professional standards, that it is serious misconduct as opposed to misconduct.

Ms Roa submitted that you misjudged how to deliver the care in a kind and compassionate way. She told the panel that in relation to human rights issues, there was a DoLs in place for Patient A and if there was not, we would be in a different legal position entirely. She submitted that it is not suggested that what you did was illegal or unlawful, it is a question of whether what you did was to such an extent that it would be serious misconduct.

Ms Rao submitted that using Colleague A's account of events, there were two occasions when she saw you holding Patient A's room door closed. Ms Rao submitted that Patient A could still receive her food and drink and that you did not prevent anyone from accessing her to give her care. She submitted that the distress, without trivialising it, was confined to periods when she was looking out the window of the door asking to be let out of the room.

Ms Rao submitted that as far as provision 2 of the Code is concerned, there is a limit to how much anyone can look after Patient A as she did not have mental capacity and her care was given on the basis of the best of care that could be given. She submitted that Patient A had difficulty communicating her needs and could not form words or sentences. She submitted that the panel can safely put provision 2 to one side and look to other areas.

In relation to provision 3.1, Ms Rao submitted that it is clear that you were paying attention but not in the right way and made a wrong judgment. She submitted that it repeats the need for compassion as already mentioned in provision 1.

In relation to provision 8.1,8,2, and 8.6, Ms Rao submitted that you went against what Colleague A had advised you to do, however you judged what was right at the time five years ago. Ms Rao submitted that this is one incident and not a pattern of behaviour. She accepted that there is a breach of the Code in this area. However, Ms Rao submitted that when the panel is making its assessment, she urged it to consider very carefully whether any identified misconduct is serious misconduct in this case, as there are often disagreements between colleagues on how a patient should be looked after.

In relation to provision 20, she submitted that you did not take alternative actions such as pulling the alarm bell or running away and by holding the door, Patient A was caused distress. She submitted that it is not a suggestion that you deliberately failed to do these things because you wanted to cause distress to Patient A, however it is a consequence of your misjudgement that caused you to take the action that you did.

Ms Rao submitted that members of the public and fellow professionals would not consider your behaviour deplorable. She submitted this was a single act as opposed to multiple acts or omissions.

Ms Rao submitted that if the panel are not with her on this matter, she referred it to the various character statements in evidence and training certificates in nursing and other disciplines you have provided. She asked the panel to also consider the written reflection and insight you have provided today. Ms Rao submitted that it should not be

held against you how you deal with the situation in the future. She submitted that the way you dealt with this was arguably wrong, that you did not pay sufficient attention to what Colleague A had said and did not follow up with your notes the following morning. Ms Rao asked the panel to take into account you that have been working for almost six years as an RMN with no regulatory concerns to your practise. She submitted that the panel can safely conclude you are not currently impaired to practice safely as a registered nurse.

In relation to the existence of a care plan, Ms Rao submitted that plainly there wasn't one. She invited the panel to assess your actions in the form it was given, which was the oral hand over from Colleague A. She submitted that in the context of the complex needs and medical history of Patient A, with no care plan, it is relevant that your conduct would perhaps be more serious if you had contravened a properly executed written care plan.

In relation to Charge 3, Ms Rao submitted that this is not serious misconduct. She submitted that it may not have been the professional thing to do and it is not uncommon to consider the circumstance in which it happened and the very difficult night it was for all involved, and being faced with that challenge you raised your voice. She submitted that in an isolated context, this would not amount to serious misconduct.

Ms Rao submitted that you are not to be punished but your impairment is an assessment of your current ability to practice and that you should not be punished for what you have done in the past. She submitted that you are not impaired and that you are fit to practise in the future.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgment, including *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311.

Decision and reasons on misconduct

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

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

> ***'1 Treat people as individuals and uphold their dignity***
> ***To achieve this, you must:***
> *1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.3 avoid making assumptions and recognise diversity and individual choice*
> *1.5 respect and uphold people's human rights*
>
> ***2 Listen to people and respond to their preferences and concerns***
> ***To achieve this, you must:***
> *2.1 work in partnership with people to make sure you deliver care effectively*
> *2.6 recognise when people are anxious or in distress and respond compassionately and politely*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> ***To achieve this, you must:***
> *3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
> *3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life*

4 Act in the best interests of people at all times

8 Work cooperatively
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
8.6 share information to identify and reduce risk,

10 Keep clear and accurate records relevant to your practice
This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.
To achieve this, you must:
10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

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
20.3 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'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

The panel considered that based on the evidence put before it you did hold Patient A's door shut on more than one occasion. You did not listen to the advice of Colleague A

who informed you during the oral handover how they normally care for Patient A. The panel determined that you did go against the advised practice for Patient A. The panel further determined that Patient A was very unhappy with your standard of care. Patient A was physically showing signs of distress and you did not respond to this behaviour. The panel was of the view that this compounds your conduct ad therefore determined that your actions were serious.

The panel considered that you approached Colleague A and in your own evidence you stated that you did raise your voice to get your point across. The panel determined that you were defending your position when you knew you had done something wrong. The panel considered that your actions fell below the standards expected of a registered nurse and amounted to misconduct, albeit not serious misconduct as per the test set out in *Roylance.*

Decision and reasons on impairment

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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) ...'

The panel finds that the first three limbs of the test are engaged. The panel determined that Patient A was put at risk and was caused emotional harm as a result of your misconduct which breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding future risk, the panel had regard to your insight, namely your written reflection, insight and remediation document provided, which states:

'If I am faced with similar situation today I am 100% sure the regulatory concerns raised by the NMC will not arise. I am now well aware of my limitations and where there is a need to consult, raised a concern or asked for help in safeguarding my patient wellbeing I will not hesitate to do so'.

Whilst noting your written submissions, the panel determined that you have not acknowledged that holding Patient A's door shut and detaining her causing her noticeable distress and emotional harm. Additionally, the panel was of the view that you have failed to demonstrate any remorse or reflected on your actions. The panel determined that you have shown limited insight and have failed to recognise the effect your actions had on colleagues or the nursing profession, or listening to staff on a ward that you were newly coming into. The panel determined that you have not provided any developing information to show what you would do if faced with a similar situation in the future.

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The panel had regard to your *Reflection document on Safeguarding adults at risk of harm and abuse: Learning from the reflection of a mental health nurse in care* settings, which indicates that you would raise concerns. However, the panel was of the view that it is an academic essay which gives an indication of your knowledge of patient care but does not deal with the circumstances of this case. The panel would have been assisted by a reflective piece which deals with the specific details of this case.

Whilst the panel noted that you state:

'Whilst I know I did my best with the patient, I can see that Colleague A was worried and I realise now that I did not deal with that as well as I should have.'

It determined that your basic insight falls far short of what is required in order to satisfy itself that you understand your behaviour and how you would deal with a similar incident in the future. The panel determined that you did not do the best for the patient.

The panel is of the view that there is a real risk of repetition at this time should similar circumstances arise. It therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; 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 determined that a finding of impairment on public interest grounds is required.
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 your fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that your name on the NMC register will show that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Submissions on sanction

Mr Badruddin, on behalf of the NMC, invited the panel to impose a six-month suspension order with a review.

Mr Badruddin highlighted what, in the NMC's view, are the aggravating factors in your case, including:

- Seclusion of a vulnerable patient without any clinical justification;
- Serious misconduct directly resulting in psychological harm and distress to Patient A;
- A disregard of information and concerns raised by colleagues around the care of Patient A;
- A failure to utilise proper de-escalation techniques;
- The continued deprivation of Patient A's liberty whilst knowing it caused the patient distress;
- An attempt to minimise the misconduct by demonstrating poor communication with colleagues;
- Clear deep-seated behavioural and attitudinal issues prevalent throughout your conduct; and
- You have demonstrated a limited level of insight, remorse and/or remediation into the misconduct or its consequences on patients, colleagues and the wider reputation of the nursing profession.

Mr Badruddin next highlighted what, in the NMC's view, are the mitigating factors in your case, including:

- The incidents occurred on one shift;
- No other referrals have been made to the NMC regarding your practice;
- No evidence of repetition; and
- At the time the charges arose you were new to that clinical environment.

Mr Badruddin submitted that taking no further action and/or imposing a caution order would not be appropriate given the seriousness of your misconduct. He stated that neither sanction would address the public protection and/or public interest concerns identified.

Mr Badruddin acknowledged that some of the concerns found proved relate to your clinical practice and are therefore capable of been remediated. However, he submitted that it would not be possible to formulate conditions which would address the more serious concerns in your case. Namely your failure to utilise de-escalation techniques, your ineffective communication with colleagues, including being confrontational and shouting and your misconduct in deliberately locking a vulnerable patient suffering from schizophrenia in their room. In light of this, Mr Badruddin submitted that a conditions of practice order would not address the public protection and public interest components that are engaged in your case.

In relation to a suspension order, Mr Badruddin submitted that the misconduct is sufficiently serious to warrant a temporary removal from the register. He reminded the panel that you have failed to address the misconduct found proved and therefore there is a significantly high risk of repetition. Mr Badruddin stated that the misconduct was a significant departure from the standards expected of a registered nurse and that imposing a lesser sanction would not sufficiently protect the public nor address the wider public interest issues stemming from your misconduct.

Ms Rao invited the panel to impose a conditions of practice order. In her submissions, Ms Rao referred the panel to the written legal advice provided at the impairment stage. Specifically:

> *'…However, should the Panel consider that the case is one where the misconduct consists of violating such a fundamental rule of the professional relationship between practitioner and patient and thereby undermining public confidence in the profession, a finding of impairment of fitness to practise may be justified on the grounds that it is necessary to reaffirm clear standards of professional conduct so as to maintain public confidence in the practitioner and in the profession. In such a case, the efforts made by the nurse to address her behaviour for the future may carry very much less weight that in a case where the misconduct consists of clinical errors or incompetence. That will be a matter for you to assess. You should pay regard to Mr Ibrahjim's (sic) attitude to the events that give rise to the specific allegations against him as something which*

can be taken into account either in his favour or against him. In terms of insight the following will assist taken from the case of Sawati v GMC 2022 EHWC 283 (Admin)…

...(1) Insight is concerned with future risk of repetition. To this extent, it is to be distinguished from remorse for the past conduct.
(2) Denial of misconduct is not a reason to increase sanction.
(3) It is wrong to equate maintenance of innocence with lack of insight. Denial of misconduct is not an absolute bar to a finding of insight. Admitting misconduct is not a condition precedent to establish that the registrant understands the gravity of the offending and is unlikely to repeat it.
(4) However, attitude to the underlying allegation is properly to be taken into account when weighing up insight. When the registrant continues to deny impropriety, that makes it more difficult for him to demonstrate insight.
(5) The assessment of the extent of insight is a matter for the tribunal, weighing all the evidence and having heard the registrant. The Court should be slow to interfere…'

Ms Rao stated that whilst you have denied the charges, this does not mean you have failed to demonstrate insight. She reiterated that it is possible to deny misconduct and still evidence how you will prevent similar problems occurring in the future. In respect of your insight, Ms Rao referred the panel to your *Fitness to Practise – Reflection, Insight & Remediation* in which you state:

'Practice effectively: by not pushing much harder to get a doctor to attend when I realised the patient was really presenting a serious challenging behaviour mean I was potentially unable to practice effectively. This meant that I did not make sure that the patient immediate need to be seen by a doctor to prescribe appropriate care were not prioritised.

Practice effectively: by not conducting comprehensive risk assessment and making at least a basic written care plan that night of how the patient were to be nurse and get a senior nurse to agree to its implementation means that I did not

practice effectively. I did take immediate and appropriate action as soon as I became aware that there was no care plan. I did not also comply with this as I did not complete all documents fully. The documents weren't complete, although at the time I was prevented from completing the notes, I should gone to the site manager, to lodge a complaint before going home.

Preserve safety: throughout the shift, I was preoccupied with the thoughts of making sure that patient does not fall. I think I have succeeding to some extent in ensuring her safety. Nevertheless, I did prevent her from leaving her room.

Promote professionalism and trust: In the light of the fact that this allegations have been found proved, I can understand how colleagues were feeling when they formed the opinion that I was failing the patient. I understand how the panel of the hearing felt I failed the patient. I have already taken measures to remedy the concerns raised. I have completing mandatory and required training, including safeguarding of children and adults and effective communication.'

Ms Rao reminded the panel that you have practiced as a registered nurse, without incident, for six years and during that time you have undertaken training in order to strengthen your practice. She submitted that a suspension order would not only be an 'over reaction' and a punishment but would not protect the public. Ms Rao referred the panel to the positive testimonials before it from your colleagues, who are fully aware of these regulatory proceedings, and nonetheless are prepared to state that they have no concerns regarding your practice. Ms Rao stated that to the contrary, your colleagues describe how they value your work and ability as a nurse.

Ms Rao asked the panel to take into consideration the 'unusual' context in which the allegations arose and submitted that it is highly unlikely that you would find yourself in that situation again.

[PRIVATE]

Ms Rao concluded by inviting the panel to find that a conditions of practice order would be appropriate, workable and address the concerns identified. She suggested a number of conditions which would allow you to continue working with your agency, be indirectly supervised, receive feedback and reflect and understand individual interactions with patients.

The panel heard and accepted the advice of legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Seclusion of a vulnerable patient without any clinical justification;
- Your misconduct deprived Patient A of her liberty, causing her considerable distress;
- Your disregard of colleague’s advice; and
- You have demonstrated only limited insight.

The panel also took into account the following mitigating features:

- Patient A did not have a defined, written care plan;
- The panel heard evidence of Patient A’s complex needs and the recent change in observation levels;
- There is no evidence before the panel of repetition since the charges arose, despite practising as a registered nurse for the past six years; and
- The charges relate to a single shift in a hospital.

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 further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict your practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the 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 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, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel accepted that you would be willing to comply with a conditions of practice order.

The panel had regard to the fact that since the charges arose you have been practising as a registered nurse, without incident for six years. It had before it a number of testimonials attesting to your clinical practice. Further, the panel has heard evidence that your agency is willing to support you should a conditions of practice order be imposed on your registration.

When taking into account the public interest concerns in your case, the panel seriously considered imposing a suspension order. However, given the mitigating factors identified in your case it determined that such an order would not be beneficial or proportionate at this time. The panel was of the view that it was in the public interest that, with appropriate safeguards, you should be able to practise as a nurse during which time you will be able to develop your insight into the misconduct of your case, develop an understanding of your failings and learn from your mistakes.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

> ‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of

educational study connected to nursing, midwifery or nursing associates.

1. You must ensure that you are working at all times on the same shift as, but not always directly observed by, a registered mental health nurse of Band 6 or above who is made aware of your conditions.

2. You must identify a mentor. The mentor must be a registered mental health nurse of Band 6 or above, employed by one of the organisations you are contracted to work and meet on a monthly basis with your mentor to review your reflective practice profile in condition three.

3. You must keep a reflective practice profile. The profile will:

   - Identify any vulnerable patients you deal with, particularly those under DOLS and those subject to strict observations and any use of de-escalation techniques;
   - Set out the nature of the care given;
   - Be signed by your observer for that patient;
   - Contain feedback from your observer on how you provide care;

You must send your case officer a copy of the reflective practice profile before any NMC hearing.

4. You must keep us informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment/agency.
   b) Giving your case officer your employer/agency's contact details.

5. You must keep us informed about anywhere you are studying for the purpose of nursing by:

a) Telling your case officer within seven days of accepting any course of study.

b) Giving your case officer the name and contact details of the organisation offering that course of study.

6. You must immediately give a copy of these conditions to:

a) Any organisation or person you work for.

b) Any agency you apply to or are registered with for work.

c) Any employers you apply to for work (at the time of application).

d) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

e) Any current or prospective patients or clients you intend to see or care for on a private basis when you are working in a self-employed capacity

7. You must tell your case officer, within seven days of your becoming aware of:

a) Any clinical incident you are involved in.

b) Any investigation started against you.

c) Any disciplinary proceedings taken against you.

8. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

a) Any current or future employer.

b) Any educational establishment for the purpose of nursing.

c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- Your attendance at the review hearing, either in person or virtually; and
- A detailed reflective piece demonstrating your insight into the charges found proved and the subsequent changes in your practice.

This will be confirmed to you in writing.

Interim order

As the conditions of practice 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 conditions of practice order 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 Badruddin who invited the panel to impose an interim conditions of practice order for 18 months in order to cover any potential appeal period. He submitted that such an order was necessary on the grounds of public protection and is otherwise in the public interest.

The panel also took into account the submissions of Ms Rao who asked that the interim order be imposed for 12 months instead of 18 months.

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover any potential appeal period.

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

That concludes this determination.