# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**Monday, 24 March - Friday, 11 April 2025**
**Wednesday, 16 – Thursday, 17 April 2025**

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

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|---|---|
| **Name of Registrant:** | **Kellie Lynn Briffa** |
| **NMC PIN** | 00J0436E |
| **Part(s) of the register:** | Registered Nurse – Sub part 1<br>RNA – (24 December 2003) |
| **Relevant Location:** | Essex |
| **Type of case:** | Misconduct |
| **Panel members:** | Philip Sayce (Chair, Registrant member)<br>Colleen Sterling (Lay member)<br>Asmita Naik (Lay member) |
| **Legal Assessor:** | Alice Robertson Rickard |
| **Hearings Coordinator:** | Eidvile Banionyte (24 March – 11 April 2025)<br>Nicola Nicolaou (16 and 17 April 2025) |
| **Nursing and Midwifery Council:** | Represented by Mohsin Malik, Case Presenter |
| **Ms Briffa:** | Not present and not represented at the hearing |
| **Facts proved:** | Charges 1b(i), 1b(ii), 1b(iii), 1c(i), 1c(ii), 1c(iii), 2, 3a, and 3b |
| **Facts not proved:** | Charge 1a(i) and 1a(ii) |
| **Fitness to practise:** | Impaired |
| **Sanction:** | **Striking-off order** |

**Interim order:** **Interim suspension order (18 months)**

**Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Ms Briffa was not in attendance and that the Notice of Hearing letter had been sent to Ms Briffa's registered email address by secure email on 12 February 2025.

Mr Malik, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and that there was an option to attend the hearing virtually, and, amongst other things, information about Ms Briffa's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Briffa has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

**Decision and reasons on proceeding in the absence of Ms Briffa**

The panel next considered whether it should proceed in the absence of Ms Briffa. It had regard to Rule 21 and heard the submissions of Mr Malik who invited the panel to continue in the absence of Ms Briffa. He submitted that Ms Briffa has voluntarily absented herself and referred the panel to the Proceeding in Absence bundle. Mr Malik submitted that Ms Briffa confirmed that she will not be attending and that she was "*no longer happy to fill in forms, documents etc"*. Mr Malik submitted that Ms Briffa has clearly indicated that she is no longer happy to engage with these proceedings. Mr Malik further submitted that the

NMC have given Ms Briffa an option to attend virtually, but no response has been received to that.

Mr Malik further submitted that Ms Briffa no longer had legal representation. He submitted that the Royal College of Nursing have come off of the record as her representatives, they stated that they would assist her in making an Agreed Removal application, however, that application was rejected by the NMC.

Mr Malik submitted that it was clear from Ms Briffa's email to the NMC, dated 11 February 2025, that she is aware of the hearing. He further submitted that there were no adjournment requests and no reason to suppose that adjourning would secure her attendance. He also confirmed that Ms Briffa did not return a completed CMS form to the NMC. Mr Malik submitted that there is a strong public interest in hearing this case expeditiously. He further submitted that there were numerous witnesses due to give evidence and the charges relate to events that occurred in 2018 so any further delay may affect how the witnesses recall the events. Mr Malik submitted that there was no good reason why this case could not proceed today and referred the panel to the cases of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* and *General Medical Council v Adeogba*.

The panel has decided to proceed in the absence of Ms Briffa. In reaching this decision, the panel has considered the submissions of Mr Malik, the email correspondence from Ms Briffa and the advice of the legal assessor. It had particular regard to the factors set out in

the decision of *R v Jones* and *General Medical Council v Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Briffa;
- Ms Briffa has responded to the email in which the NMC have sent her the Notice of the Hearing and confirmed that she will not be attending the hearing and will not be filling out any further paperwork;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- A number of witnesses have been scheduled to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2018 and further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Briffa in proceeding in her absence. Although the evidence upon which the NMC relies was sent to her at her registered address, she has made no response to the allegations. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Briffa's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

**Details of charge**

*That you, a Registered Nurse, at HMP Chelmsford, in relation to Patient A on 22 August 2018*

1. Having been told and/or having formed the view that Patient A had taken drugs, or in any event, you:

    a) Failed to undertake an adequate assessment of Patient A after he had been searched in Reception, in that:

        i) You did not take vital signs observations
        ii) You did not use his medical records to inform your assessment of his condition.

    b) Whilst Patient A was in the holding cell, you failed to undertake an adequate assessment, in a timely manner, in that:

        i) You did not take and/or monitor vital signs observations
        ii) You did not physically examine him
        iii) You failed to use his medical records to inform your assessment of his condition.

    c) Whilst Patient A was in the holding cell, you failed to:

        i) treat his injuries

ii) have sufficient regard for his safety in that you did not intervene, or adequately intervene, to prevent further injury

iii) escalate the situation in that you did not seek advice and/or call an ambulance, in a timely manner

2. Failed to fully document Patient A's condition and injuries contemporaneously and/or in a timely manner.

3. Made one or more insensitive and/or offensive comments about Patient A by saying:

a) "… he always looks this gormless though" or words to that effect;
b) "I've been here for the last hour with this idiot" or words to that effect.

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**

At the outset of the hearing, Mr Malik made a request that this case be held in private when the CCTV footage is being viewed during the hearing to protect the identity of Patient A. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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 when the CCTV footage is being viewed so as to protect Patient A's identity.

**Decision and reasons on application to admit hearsay evidence of Witnesses 9, 10, 11, 12 and 13**

The panel heard an application made by Mr Malik under Rule 31 to admit various accounts of Witness 9, 10 and 13 and the reports of Witness 11 and 12 into evidence.

Mr Malik referred the panel to the hearsay bundle. He further referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and reminded the panel about the factors that it ought to consider when deciding whether to admit hearsay evidence.

Referring to Witnesses 9, 10 and 13, who were prison officers, Mr Malik applied to admit the following hearsay evidence:

- Prison investigation interview with Witness 9;
- Prison and Probation Ombudsman telephone interview with Witness 13;
- Prison Investigation interview with Witness 13 on 9 October 2018 and 19 March 2019;
- The transcript of Witness 13's evidence at the coroner's inquest; and
- Prison Investigation Interview with Witness 10.

Mr Malik submitted that these documents are not sole or decisive in support of any of the charges.

Mr Malik submitted that Witness 9 was present on the day of the incident during some of the time in reception and confirmed Ms Briffa was present. He speaks about the condition Patient A was in and the condition of the cell. He further submitted that Witness 13 confirmed that Patient A was not being aggressive towards staff and that there was no threat felt from him.

With regards to Witness 10, Mr Malik submitted that the witness saw Patient A banging his head on the floor and also described Patient A's condition. He further confirmed in the interview that Ms Briffa said she was not going to clean Patient A's cuts because he would just keep reopening them by banging his face on the floor. Mr Malik further told the panel that it was Witness 10's evidence that someone told him that an ambulance was not needed and that healthcare did not want an ambulance. It is also Witness 10's evidence that Ms Briffa told him that this was more than alcohol and that she did not do observations saying there was no point.

Mr Malik submitted that the panel had seen the CCTV and had heard from live witnesses about the opportunities Ms Briffa had to go in and do the observations and to check vital signs.

Mr Malik submitted that Ms Briffa and/or her representatives did not raise any challenge to the contents of these documents.

Mr Malik submitted that there was no suggestion that these witnesses had reasons to fabricate their allegations. He submitted that the CCTV footage clearly shows what happened on the day.

Mr Malik submitted that the charges are serious and could have implications for Ms Briffa's career. However, he reminded the panel that Ms Briffa did make an Agreed Removal application which was refused. He submitted that this indicated that she did not wish to practise as a nurse and in terms of any adverse findings against her, the admission of this evidence would have a very limited impact on her career.

In relation to the non-attendance of the witnesses and whether the NMC had taken reasonable steps to secure their attendance, Mr Malik submitted the following:

- Witness 9 was emailed and chased several times. Mr Malik advised the panel on the correspondence history with this witness and submitted that the NMC

have taken reasonable steps to secure his attendance.

- Witness 13 told the NMC that she did not wish to get involved in this matter on 23 December 2024 and confirmed the same on 23 February 2025.
- Witness 10 also told the NMC that he did not wish to partake any further in correspondence dated 24 December 2024. He said that this has taken over five years of his life and that he would like to put it behind him and move on.

Mr Malik submitted that the NMC have taken reasonable steps to secure the attendance of these three witnesses, and that Ms Briffa had prior notice that the NMC will be relying on these documents. He submitted that these documents are relevant and that it would be fair to admit them into evidence.

In relation to two expert reports by Witnesses 11 and 12, Mr Malik submitted that these were clearly relevant. He submitted that Witness 11 is a nursing expert and is one of the clinical reviewers who reviewed Ms Briffa's case and wrote a report. He submitted that she does not say anything different to what Witness 8 says. He submitted that Witness 11's evidence is not sole or decisive evidence in relation to any of the charges and a lot of what is mentioned in her report can be seen on the CCTV.

In relation to the NMC taking reasonable steps to secure the attendance of Witnesses 11, Mr Malik conceded that no attempts were made to secure her attendance. He told the panel that this is because she does not say anything which is different to Witness 8, who was the chair of the panel that conducted the clinical review. Mr Malik submitted that Ms Briffa knew that the NMC would be relying on Witness 11's report, as the bundle was sent to her and no objections were raised.

Regarding Witness 12, she is an emergency medicine expert. Mr Malik submitted that this witness does not say anything different to what Witness 8 told the panel and that her evidence is corroborated by other witnesses from whom panel has already heard. He told the panel that the NMC had not made any efforts to secure this witness' attendance for the same reasons as Witness 11.

Mr Malik further submitted that both Witness 11 and 12 are experts and there is no reason to suggest any fabrication of their evidence. He submitted that it would be fair and relevant to admit both these expert reports into evidence.

In answering the panel's question on the potential of Witness 9 fabricating his evidence, as it is alleged that [PRIVATE], Mr Malik submitted that CCTV footage shows exactly what happened. He submitted that whilst there is a potential for Witness 9 having a reason to fabricate his evidence, this witness speaks to narrow issues in his evidence in that he describes the condition of the cell and condition of Patient A which is corroborated by the CCTV footage.

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. The legal assessor also referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council*.

In reaching its decision the panel considered the evidence of each witness separately.

Witness 9. The panel determined this evidence to be relevant but not sole or decisive and reminded itself that the issues addressed by Witness 9 were contained within the CCTV evidence. This witness described the physical condition of Patient A and commented on whether Ms Briffa was doing the observations. His perception of Patient A aligned with Ms Briffa's perception. The panel determined that Ms Briffa was warned about the NMC relying on Witness 9's evidence and has not challenged it. The panel accepted that whilst there could be a good reason to suggest fabrication of evidence in Ms Briffa's favour, it reminded itself that it can make a judgment about its reliability and weight at the facts stage and compare this evidence to any other evidence in the case. The panel acknowledged that these were serious charges but balanced this against the other factors it had to consider. The panel noted that the NMC have taken some steps to secure

Witness 9's attendance and determined that on balance, it would be fair to admit this into evidence.

Witness 10. The panel determined that the evidence of this witness was not sole or decisive and that his evidence is covered by the CCTV footage. The panel noted that there was no substantive challenge regarding this witness' evidence and considered that there was no real reason to fabricate. The panel acknowledged that these were serious charges but balanced this against the other factors it had to consider. The panel noted that the NMC have taken some steps to secure this witness's attendance. He stated that, after taking advice, he had made a decision to decline to give evidence. The panel determined that this was not a good reason for his non-attendance but was of the view that on balance, it was fair to admit this into evidence.

Witness 11. The panel determined that this evidence was not sole or decisive as it was corroborated by Witnesses 7 and 8 and the CCTV footage. The panel noted that this evidence was not challenged by Ms Briffa and that there was no reason to suggest fabrication. With regards to non-attendance, the panel noted that there were no efforts made by the NMC to secure this witness' attendance. The panel determined that whilst it gave serious consideration whether to direct the NMC to make attempts to secure this witness, as Ms Briffa was not here to cross-examine this witness and this evidence was supported by two other witnesses, it was, on balance, fair to admit this evidence. The panel also noted that whilst no express notice was given to Ms Briffa that the NMC will be relying on this witness' evidence, her report was annexed to the report of Witness 8 upon which the NMC were expressly relying.

Witness 12. The panel noted that the conclusions of this expert were addressed by other witnesses in this case and therefore this report was not sole and decisive. The panel noted that there was no particular challenge regarding this evidence and there were no suggestions of fabrication. The panel acknowledged that these were serious charges but balanced this against the other factors it had to consider. The panel determined that whilst

there were no attempts made by the NMC to secure this witness, however, the same reasoning as per Witness 11's evidence admission applied here.

Witness 13. The panel determined that this evidence was not sole and decisive. The panel noted that this witness states that she spoke to Ms Briffa about Patient A overdosing, and Ms Briffa denies being told this. The panel noted that whilst some aspect of this evidence is challenged, the charge to which it relates is broader than that and is supported by other witnesses and the CCTV evidence. The panel was not aware of any reason for fabrication, except the allegations of a general culture of coverups in the prison. The panel acknowledged that these were serious charges but balanced this against the other factors it had to consider. With regards to the reasons for non-attendance, the panel noted that this witness did not wish to continue participating in the proceedings having said that she had already attended the coroner's court regarding this case which was "*particularly harrowing*" and is involved in three other incidents relating to deaths of prisoners. The panel did not consider this to be a good reason for non-attendance at this hearing. However, overall, the panel decided that it would be fair to admit this evidence.

In these circumstances, the panel came to the view that it would be fair and relevant to admit the evidence of Witnesses 9, 10, 11, 12 and 13 but that the panel would give it what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

**Background**

The allegations against Ms Briffa arose following the death of Patient A, who was a prisoner at HMP Chelmsford (the Prison).

On 22 August 2018, Patient A was due to be transferred to a different prison. During the morning, prison officers faced challenges with Patient A who did not want to be moved and reported taking an overdose. Officers took Patient A to the reception area, where Ms Briffa and reception staff considered that Patient A was intoxicated with alcohol.

Following this, a decision to place him in a holding cell to “sober up” was made. It is alleged that Ms Briffa remained in the area, but that she did not undertake any assessment or observations of Patient A. It is further alleged that she failed to fully document Patient A’s condition and injuries.

Throughout Patient A’s time in the holding cell, his condition appeared to deteriorate. It is alleged that Ms Briffa and a healthcare assistant carried out observations approximately two hours after Patient A first arrived in the reception area. At this stage, he was unresponsive and had suffered various injuries. An ambulance was called and Patient A was taken to hospital.

Patient A died on 30 August 2018. The medical cause of death was recorded as multiple organ failure and multiple drug toxicity.

**Decision and reasons on facts**

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

The panel has drawn no adverse inference from the non-attendance of Ms Briffa.

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

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

- Witness 1: Healthcare Assistant for the Trust at the time of the incident

- Witness 2: Head of Business Assurance
- Witness 3: Senior Registrar in Forensic Psychiatry employed by the Trust at the time of the incident
- Witness 4: Health Care Support Worker at HMP Chelmsford at the time of the incident
- Witness 5: Head of Safer Custody, Diversity and Inclusion at the Trust at the time of the incident
- Witness 6: Performance Improvement Manager, Operational, at HMP Chelmsford at the time of the incident
- Witness 7: Head of Healthcare and Partnership Integration Manager for Medical Services at HMP Chelmsford at the time of the incident
- Witness 8: Chair of the Level 3 Panel Review, Clinical Review Panel. Medical doctor and General Practitioner.

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

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

**Charge 1a**

That you, a Registered Nurse, at HMP Chelmsford, in relation to Patient A on 22 August 2018, having been told and/or having formed the view that Patient A had taken drugs, or in any event, you:

a) Failed to undertake an adequate assessment of Patient A after he had been searched in Reception, in that:

i) You did not take vital signs observations

ii) You did not use his medical records to inform your assessment of his condition.

**This charge is found NOT proved.**

In reaching this decision, the panel took into account the CCTV footage, and the evidence of Witnesses 7 and 8.

The panel reviewed the CCTV footage and noted that Ms Briffa attended the reception area at around 11:17 and that Patient A was moved to the holding cell at 11:22. The panel determined that this meant that since Ms Briffa's arrival, Patient A was in the reception area for around four minutes only.

The panel noted Witness 7's evidence in which he said that the first opportunity to take observations would have been at 11:33, when Patient A was in a holding cell and not the reception area.

The panel also noted Witness 8's evidence in which he stated that Ms Briffa should have assessed Patient A upon her arrival at the reception area. However, the panel determined that by the time Patient A was made safe by the prison officers, he was then transferred to the holding cell, within four minutes of Ms Briffa's arrival to the reception area.

The panel determined that given the short space of time and the fact that the prison officers were still searching and making sure Patient A was safe, there would not have been a realistic opportunity for Ms Briffa to take vital signs observations or use Patient A's medical records to inform her assessment of his condition whilst in the reception area.

The panel therefore found this charge not proved.

**Charge 1b**

That you, a Registered Nurse, at HMP Chelmsford, in relation to Patient A on 22 August 2018, having been told and/or having formed the view that Patient A had taken drugs, or in any event, you:

b) Whilst Patient A was in the holding cell, you failed to undertake an adequate assessment, in a timely manner, in that:

i) You did not take and/or monitor vital signs observations

ii) You did not physically examine him

iii) You failed to use his medical records to inform your assessment of his condition.

**This charge is found proved.**

The panel determined that there was insufficient evidence before it to conclude that Ms Briffa had been told that Patient A had taken drugs. The panel noted Witness 13's evidence that she had spoken to Ms Briffa about Patient A overdosing, however, it considered that this was untested hearsay evidence, and that Ms Briffa denied being told this. The panel could not say that it was more likely than not that Ms Briffa was told about Patient A having taken drugs.

However, the panel was satisfied that Ms Briffa had formed the view that Patient A had taken drugs. The panel noted that at 12:26 in the CCTV footage, Ms Briffa verbalises her view that *"it can't just be alcohol"*.

It was further satisfied, that "in any event" Ms Briffa had a duty to assess Patient A in the holding cell, due to Patient A's deteriorating condition.

Having viewed the CCTV footage, the panel accepted Witness 7's evidence in relation to examples of specific times that there would have been an opportunity for Ms Briffa to take Patient A's observations:

- 11:38. Patient A is not presenting as aggressive;
- 11:56. Patient A is sat on the bench with two officers in the cell holding him, no signs of aggression;
- 12:05. Patient A is on the floor, Ms Briffa does not go in, but the cleaner does. Witness 7 suggested that if Patient A was aggressive, the cleaner would not have been permitted to enter the cell to do the cleaning. Ms Briffa is seen outside the cell laughing;
- 12:23. Patient A's face is bleeding;
- 12:24. Patient A was screaming in pain;
- 12:27. Patient A's breathing is laboured. Witness 7 confirmed that this was an emergency situation where Ms Briffa was required to intervene immediately. The panel noted that this was corroborated by Witness 8, who confirmed that this was the time where Ms Briffa needed to step in immediately given the respiratory signs. The panel determined that at this stage, given Patient A's deterioration, this became an emergency situation.
- 12:30. Patient A is sat on the floor being held by two prison officers. Another nurse with an emergency bag appeared;
- 12:32. Patient A was apparently unconscious, legs twitching.
- 12:33. Patient A was immobile on the floor and the prison officers were holding him, leaning him forward. Ms Briffa was in attendance, observing from a far. Witnesses 7

and 8 both confirmed that this positioning could have obstructed Patient A's airway and breathing and Ms Briffa needed to step in;

- 12:44. Patient A in a recovery position;
- 12:47. Ms Briffa is seen having a cup of tea;
- 12:58. Ms Briffa is stood at the door, talking to the prison officer. Patient A's breathing could have been compromised at this point;
- 13:05-13:17. Patient A rolling around on the floor;
- 13:17. Patient A stands and falls to the ground;
- 13:26. Witness 1 starts doing visual observations and undertakes vital signs observations shortly after.

The panel noted Witness 7's evidence that Ms Briffa had easy access to System 1 which was in a nearby room. Both Witnesses 7 and 8, confirmed that access to Patient A's records would have provided Ms Briffa with useful information regarding his care and that she should have accessed them. The panel noted Ms Briffa's admission, in her statement prepared for the inquest, that she did not access Patient A's records as she was made to believe by prison officers that Patient A was drunk.

The panel determined that there were multiple opportunities within the timeframe above to undertake observations, physically examine Patient A and to use his medical records to inform her assessment of his condition. The panel determined that a duty to perform this arose due to Patient A's presentation and deterioration in his condition. The panel determined that Ms Briffa failed to undertake an adequate assessment of Patient A, in a timely manner, as per this charge.

The panel found this charge proved in its entirety.

**Charge 1c**

That you, a Registered Nurse, at HMP Chelmsford, in relation to Patient A on 22 August 2018, having been told and/or having formed the view that Patient A had taken drugs, or in any event, you:

c) Whilst Patient A was in the holding cell, you failed to:

i) treat his injuries

ii) have sufficient regard for his safety in that you did not intervene, or adequately intervene, to prevent further injury

iii) escalate the situation in that you did not seek advice and/or call an ambulance, in a timely manner

**This charge is found proved.**

The panel considered this charge in sub-charges:

*i) treat his injuries*

The panel accepted the evidence of Witness 7, who said that there were things Ms Briffa could have done to treat Patient A's injuries. Witness 7 stated that Ms Briffa should have attended to Patient A's wounds and taken charge of the situation to preserve his airways, she should have attended to Patient A as soon as there were visible injuries. Witness 7 confirmed that at least at 12:04 there were visible injuries, with blood around the cell. The panel noted that at that time, a cleaner attended the cell to clean the blood and Ms Briffa offered him a cloth but did not tend to Patient A. The panel determined that it would have been safe for Ms Briffa to attend to Patient A and treat his injuries not only at this time, but at multiple times as discussed in the previous charge.

The panel found this sub-charge proved.

*ii) have sufficient regard for his safety in that you did not intervene, or adequately intervene, to prevent further injury*

The panel noted Witness 8's evidence that it was mainly the prison officers who had the duty to intervene when prisoners were harming themselves or when they were endangering themselves.

The panel further noted that Ms Briffa claimed that she had spoken to the prison officers about getting a mattress and bringing Patient A to the reception area, which was refused. Witness 2 denied any such discussions. The panel accepted that there was conflicting evidence as to whether or not Ms Briffa requested Patient A to be moved but found that even if Ms Briffa's account was correct, there was more she could have done for Patient A.

The panel accepted Witness 7's evidence that Ms Briffa could at least have put a pillow or towel under Patient A's head to prevent further injury.

The panel acknowledged Ms Briffa's case that she could not have entered the holding cell as she believed it was dangerous. The panel also noted that Witness 1's evidence on the face of it appeared to support this contention. However, the panel accepted Witness 1's evidence at the hearing when she explained to the panel that she was writing the incident report in the room when Ms Briffa was there and after Patient A had passed away and that she felt under pressure to write what she did.

The panel preferred the evidence of Witnesses 7 and 8, suggesting that there were plenty of safe opportunities to enter the cell and to do observations and this was confirmed by the panel's viewing of the CCTV footage. It therefore rejected Ms Briffa's contention that it was not safe for her to enter the cell.

The panel determined that Ms Briffa did not have sufficient regard to Patient A's safety, and she did not intervene to prevent further injury when she should have done so.

The panel found this sub-charge proved.

*iii)* escalate the situation in that you did not seek advice and/or call an ambulance, in a timely manner

The panel determined that an emergency situation arose at 12:27, when Patient A's breathing was laboured. Witnesses 7 and 8 confirmed that Patient A should have been transferred to the hospital at that time.

The panel noted that Ms Briffa in her interview on 23 September 2019 conceded that in hindsight, she should have called the ambulance sooner. In her further reflection, she also acknowledged that she did not escalate this situation to managers or call for an ambulance in a timely manner.

The panel found this sub-charge proved.

The panel therefore found this charge proved in its entirety.

**Charge 2**

> That you, a Registered Nurse, at HMP Chelmsford, in relation to Patient A on 22 August 2018, failed to fully document Patient A's condition and injuries contemporaneously and/or in a timely manner.

**This charge is found proved.**

In reaching this decision, the panel took into account Patient A's medical records, Witness 7's, 8's and 11's evidence, as well as the CCTV footage.

The panel had regard to written evidence from Witness 11, who was a nursing expert. The panel accepted Witness 11's evidence that there was a duty on Ms Briffa to make contemporaneous notes of Patient A's condition.

The panel also considered Witness 7's evidence that another nurse taking over the care of this patient would not have had a full understanding of their care and deterioration given the limited records.

The panel reviewed Patient A's medical records and noted that there was no entry until 13:06, which indicated a delay in entering these records as Ms Briffa was called at around 11:17.

The panel determined that the entry made by Ms Briffa in relation to Patient A's condition and injuries was not sufficiently contemporaneous. Moreover, the panel was of the view that the entry made in the records did not accurately reflect what is seen on the CCTV footage. The panel further determined that it did not adequately reflect the changes to Patient A's condition which should have been fully documented. The panel also noted that there was ample time to make records as the CCTV shows Ms Briffa standing around for lengthy periods.

The panel also took into account Ms Briffa's admission in her reflective statement where she acknowledged that the documentation should have been more detailed.

Taking all of the above into account, the panel found this charge proved.

**Charge 3**

> That you, a Registered Nurse, at HMP Chelmsford, in relation to Patient A on 22 August 2018, made one or more insensitive and/or offensive comments about Patient A by saying:
>
> a) "… he always looks this gormless though" or words to that effect;
>
> b) "I've been here for the last hour with this idiot" or words to that effect.

**This charge is found proved.**

In reaching this decision, the panel took into account the CCTV footage and Witness 10's evidence.

With regards to charge 3a, the panel relied on CCTV footage in which at 11:17 (in real time) it can be heard that Ms Briffa said *"… he always looks this gormless though"* when in the reception area.

The panel noted the dictionary definition of *"gormless"* as lacking sense or being foolish and determined that it was an insensitive and offensive way to talk about a patient.

The panel found this part of the charge proved.

With regards to charge 3b, the panel relied on CCTV footage in which at 12:24 (in real time) it could be heard that Ms Briffa said, *"I've been here for the last hour with this idiot".*

The panel took into account Witness 10's account, who, when questioned by the coroner at an inquest hearing, confirmed that he heard Ms Briffa saying this comment. The panel noted that it was this witness' body worn footage that was the direct evidence of Ms Briffa saying this comment.

The panel noted the dictionary definition of an *"idiot"* as a stupid person, a person of low intelligence. The panel determined that this was an insensitive and offensive way to talk about a patient, particularly at a time when he was in need of urgent medical attention. The panel further determined that members of the public and fellow nurses would also find this to be an insensitive and offensive way to talk about a patient. The panel also noted Witness 7's evidence in which he said that this was an *"absolutely disgraceful"* way to talk about a patient.

The panel found this part of the charge proved.

Therefore, this charge is found proved in its entirety.

**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 Ms Briffa's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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, Ms Briffa's fitness to practise is currently impaired as a result of that misconduct.

**Submissions on misconduct**

Mr Malik referred the panel 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.'* He further referred the panel to the cases of *Calhaem v GMC* [2007] EWHC 2606 (Admin) and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), to assist with the definition of misconduct and serious misconduct.

Mr Malik submitted that Ms Briffa's actions fell short of the standards set out in The Code: Professional standards of practice and behaviour for nurses and Midwives (2015) ("The Code") and referred the panel to the relevant paragraphs of the Code.

He submitted that the charges found proved are serious and that the panel was satisfied that Ms Briffa had a duty to assess Patient A in the holding cell, due to Patient A's presentation and deteriorating condition. There were multiple opportunities to undertake observations, physically examine Patient A and to use his medical records to inform her assessment of his condition. Mr Malik submitted that Ms Briffa failed to undertake an adequate assessment of Patient A in a timely manner. Mr Malik submitted that Ms Briffa made insensitive and offensive comments about Patient A, at a time when he was in need of urgent medical attention.

Mr Malik referred the panel to the NMC Guidance FTP- 3 "How we determine seriousness" which lists some behaviours which are particularly serious as they suggest there may be a risk to people receiving care; examples include conduct or poor practice which indicates a dangerous attitude to the safety of people receiving care.

Mr Malik invited the panel to find that Ms Briffa's actions in charges 1b, 1c, 2 and 3 amounted to misconduct.

**Submissions on impairment**

Mr Malik moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Malik submitted that the first three limbs of *Grant* were engaged in this case.

With regards to limb a, Mr Malik submitted that Ms Briffa's actions had put a patient at an unwarranted risk of harm by not undertaking an adequate assessment, in a timely manner. Ms Briffa failed to treat Patient A's injuries and did not have sufficient regard for his safety in that she did not intervene to prevent further injury. He further submitted that in her reflection, Ms Briffa acknowledged that she was accountable for not escalating to managers/the ambulance service in a timely manner, which allowed time for Patient A to harm himself further. Mr Malik submitted that in the absence of full insight and remediation, the risk of repetition and future harm remains.

With regards to limbs b and c, Mr Malik submitted that Ms Briffa's actions have brought the nursing profession into disrepute, she has breached fundamental tenets of the nursing profession by not keeping to and upholding the standards and values as set out in The Code. He submitted that the conduct found proved in this case undermines the public's trust and confidence in the profession and could result in patients, and members of the public, being deterred from seeking nursing assistance when needed.

Mr Malik submitted that a finding of impairment is required to mark the seriousness of the misconduct, emphasise the importance of the fundamental tenet breached, and to reaffirm proper standards of behaviour.

Mr Malik submitted that the misconduct in this case is directly linked to Ms Briffa's clinical practice and is indicative of her attitudinal issues. He submitted that attitudinal issues are more difficult to put right and referred the panel to the NMC guidance entitled "Serious concerns which are more difficult to put right" (FTP-3a).

Mr Malik further referred the panel to Ms Briffa's reflective statement, which was written some time ago.

He submitted that the misconduct in this case is not easily remediable, the concerns have not been remediated and that they are therefore highly likely to be repeated.

Mr Malik invited the panel to find impairment on public protection grounds and in the wider public interest.

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

**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 Ms Briffa's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Briffa's actions amounted to a breach of the Code. The panel accepted Mr Malik's submissions and also itself considered the Code and found the following standards were breached by Ms Briffa:

*'**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*

*1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

*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:*

*2.6 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:*

*3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care*

***8 Work co-operatively***

*To achieve this, you must:*

*8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*

*8.2 maintain effective communication with colleagues*

*8.5 work with colleagues to preserve the safety of those receiving care*

***10 Keep clear and accurate records relevant to your practice***

*To achieve this, you must:*

*10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*

*10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

***13 Recognise and work within the limits of your competence***

*To achieve this, you must:*

*13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care*

*13.2 make a timely referral to another practitioner when any action, care or treatment is required*

***15 Always offer help if an emergency arises in your practice setting or anywhere else***

*To achieve this, you must:*

*15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly*

***16 Act without delay if you believe that there is a risk to patient safety or public protection***

*To achieve this, you must:*

*16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices*

***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'*

Charges 1b and 1c. The panel determined that these sub-charges, both individually and collectively, amounted to misconduct. They involved clinical failings, which put Patient A at a real risk of harm. The panel noted Witness 1's evidence that Ms Briffa was *"unphased, unbothered, with no form of compassion or care"*. The panel found that this amounted to misconduct.

Charge 2. The panel noted that this charge related to record keeping. The panel noted Witness 7's evidence in which he stated that a nurse taking over the care of Patient A, would not have had the correct understanding of his care and deterioration due to the quality of the records. This could put Patient A at real risk of harm. The panel found that this amounted to misconduct.

Charge 3. The panel considered that this charge was indicative of serious attitudinal issues and demonstrated Ms Briffa's uncaring attitude towards Patient A. The panel noted Witness 7's evidence in which he told the panel that the way Ms Briffa spoke about Patient A was *"absolutely disgraceful"*. The panel found that this amounted to misconduct.

In making the decision regards misconduct the panel considered NMC guidance FTP-2a 'Misconduct' and FTP-3 'How we determine seriousness'.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Ms Briffa's actions, cumulatively and individually, breached a number of fundamental tenets of the profession, and related to clinical failings, record keeping, and attitudinal issues.

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

**Decision and reasons on impairment**

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

*‘The question that will help decide whether a professional’s fitness to practise is impaired is:*
*“Can the nurse, midwife or nursing associate practise kindly, safely and professionally?”*
*If the answer to this question is yes, then the likelihood is that the professional’s fitness to practise is not impaired.’*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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 determined that Ms Briffa's past behaviour had put Patient A at an unwarranted risk of harm. The panel noted Ms Briffa's most up-to-date reflective statement in which she stated that since this incident, she has always called for an ambulance, however, the panel did not have the opportunity to explore this with her or any evidence to support this claim. The panel further determined that Ms Briffa's reflection and account of the events did not overall align with the events captured in the CCTV footage. The panel found Ms Briffa's recounting of events to be self-serving and not supported by any evidence that the panel has seen. The panel determined that the reflection sought to minimise Ms Briffa's role during the time that Patient A was under her care and it was not based on a sound understanding of what had happened or what was required of her in that situation.

The panel recognised that Ms Briffa might have some remorse, however, because her reflection minimised the impact of her misconduct, it raises questions about her attitude towards patients in need of urgent care. The panel therefore determined that Ms Briffa's insight is extremely limited. The panel determined that there was nothing before it today to suggest that the risk of harm has reduced and determined that there remains a significant risk of harm towards patients.

The panel heard evidence and acknowledged that there may have been a culture of disregard for prisoner welfare in the prison at the time of the incident. The panel

considered whether this context could have affected Ms Briffa's care towards Patient A. However, the panel noted that Witness 1 was able to act promptly in providing care and in carrying out observations on Patient A upon her arrival and therefore the panel did not consider that culture of the prison at the time prevented Ms Briffa from caring for Patient A appropriately.

The panel further determined that Ms Briffa, through her misconduct, has breached the Code and brought the profession into disrepute. The panel determined that other prisoners, knowing how Ms Briffa treated Patient A, could have less trust in the nursing staff. The panel further determined that following her misconduct in regard to record keeping, another colleague might be less likely to trust her account of or rely on her documentation about patient care. The panel had regard to Witness 1's evidence in which she said that *"Kelly did not seem to care, officers did not seem to care. I felt hopeless for him and it broke my heart"*. The panel determined that Ms Briffa's conduct fell far below the standard expected of a nurse and would be seen as deplorable by other registrants and the public.

The panel further determined that Ms Briffa has breached the fundamental tenets of the profession. The panel determined that she failed to maintain Patient A's safety, to advocate for him, and disregarded his needs. The panel determined that Ms Briffa's conduct demonstrated that she is unable to practise kindly, safely and professionally.

The panel had regard to the NMC guidance FTP-3a on Serious concerns which are more difficult to put right. The panel was of the view that the misconduct in this case is difficult to remediate. The panel determined that the clinical concerns in this case arose not due to Ms Briffa's clinical competence, but due to her attitude towards patients, which is very difficult to remediate and was suggestive of deep-seated attitudinal issues.

The panel further noted that there was very little before it today to suggest that she has strengthened her practice or has taken steps to address the misconduct. There was only one training certificate, which the panel considered to be negligible evidence of

remediation given that six years have passed since the incident. Furthermore, the panel has not been provided with any testimonials or references.

The panel was of the view that there is a substantial risk of repetition based on lack of any meaningful remorse or remediation. The panel 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 because a well-informed member of the public, aware of all the facts of the case, would be shocked if a finding of impairment was not made against Ms Briffa.

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 Ms Briffa's fitness to practise impaired on the grounds of public interest.

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

**Sanction**

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

In reaching this decision, the panel 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 Malik informed the panel that in the Notice of Hearing, dated 12 February 2025, the NMC had advised Ms Briffa that it would seek the imposition of a striking-off order if it found her fitness to practise currently impaired.

Mr Malik identified the following aggravating features in this case:

- Limited remediation and insight
- Conduct which put a patient at risk of suffering harm

Mr Malik did not identify any mitigating features in this case.

Mr Malik submitted that taking no further action, or imposing a caution order would not be appropriate or proportionate. He submitted that given the serious nature of the concerns, taking no further action, or imposing a caution order would not be sufficient to protect the public, maintain professional standards, or uphold public confidence in the nursing profession or the NMC as the regulator.

Regarding a conditions of practice order, Mr Malik submitted that the conduct in this case is difficult to remediate and is suggestive of deep-seated attitudinal issues. Mr Malik submitted that Ms Briffa has not provided any evidence to demonstrate strengthening of her practice or steps taken to address her misconduct. Mr Malik submitted that no workable conditions could be formulated that would address the concerns in this case

Regarding a suspension order, Mr Malik submitted that there is nothing before the panel to suggest that the risk of harm has reduced and therefore submitted that a suspension order

is not appropriate as the conduct in this case is fundamentally incompatible with Ms Briffa remaining on the register.

Mr Malik submitted that the concerns in this case are serious and highlight a deep-seated attitudinal issue. He submitted that the nature and seriousness of Ms Briffa's conduct calls into question her professionalism. He submitted that trust and confidence in the nursing profession can only be maintained by striking Ms Briffa off the register. Mr Malik therefore submitted that a striking-off order is the only appropriate and proportionate sanction in this case.

The panel accepted the advice of the legal assessor.

**Decision and reasons on sanction**

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

The panel considered the following to be aggravating features:

- Limited remediation and insight
- Conduct which put a vulnerable patient at risk of suffering actual harm

The panel did not identify any mitigating features in this case.

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

The panel next considered whether placing conditions of practice on Ms Briffa's registration would be a sufficient and appropriate response. The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. It determined that the misconduct identified in this case is suggestive of a deep-seated attitudinal problem which is difficult to remediate, and not something that can be easily addressed. Furthermore, the panel concluded that the placing of conditions on Ms Briffa's registration would not adequately protect the public, nor address the public interest given the seriousness of this case.

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

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

- …

Whilst the panel acknowledged that this was a single instance of misconduct, and that there was no evidence of repetition of the behaviour, the conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel took into account Ms Briffa's very limited insight, and that her reflective piece sought to minimise her actions. The panel determined that the misconduct is extremely serious and that Patient A, who was vulnerable, suffered unnecessary pain, suffering, and distress as a result of Ms Briffa's lack of care.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

Ms Briffa's actions are fundamentally incompatible with her remaining on the register. The panel considered that Patient A, who was a prisoner, was dependent on Ms Briffa to provide medical assistance at a time where his healthcare options were limited due to his incarceration. It further determined that Ms Briffa's disregard for Patient A's care was callous and raised fundamental questions about her professionalism. The panel was of the view that the findings in this particular case demonstrate that Ms Briffa's actions were serious and to allow her 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 Ms Briffa's 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 this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Ms Briffa 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 Ms Briffa's 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 Mr Malik. He submitted that an 18-month interim suspension order is necessary in this case to allow time for any period of appeal.

The panel accepted the advice of the legal assessor.

**Decision and reasons on interim order**

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

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

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

That concludes this determination.