Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 26 August 2025 – Friday, 29 August 2025
Monday, 1 September – Wednesday, 3 September 2025

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

Name of Registrant:	**Marie Louise Fiske**
NMC PIN:	01A0289E
Part(s) of the register:	Registered Nurse – Mental Health Sub Part 1 (24 January 2004)
Relevant Location:	Middlesbrough
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, lay member) Anne Rachael Browning (Registrant member) Jennifer Portway (Lay member)
Legal Assessor:	Oliver Wise (26 August – 28 August 2025, 1 September – 3 September 2025) Georgina Goring (29 August 2025)
Hearings Coordinator:	Hanifah Choudhury (26 August 2025) Samara Baboolal (27 August – 3 September 2025)
Nursing and Midwifery Council:	Represented by Kir West-Hunter, Case Presenter
Miss Fiske:	Present and represented by Simon Holborn, instructed by NMC Watch
No case to answer:	Charge 1(a), 1(b)
Facts proved:	Charge 1(c)
Facts not proved:	Charge 1(d)

Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application to amend the charges

The panel heard an application made by Ms West-Hunter, on behalf of the Nursing and Midwifery Council (NMC), to amend the wording of charge 1c and to add in a new charge of 1d.

The proposed amendments were:

1) On 23 January 2024 whilst dealing with Patient A:

~~c) Kicked~~ **attempted to kick** them

d) The attempted kick by you made contact with Patient A

Ms West-Hunter submitted that, taken together, the new charges would be the same as the previous charge 1c.

Ms West-Hunter submitted that the reason for the separation of the charges is so that the panel may find that there may be a differentiation between the intention of your alleged kick and the outcome of it. She submitted that, in respect of your alleged kick towards Patient A, CCTV footage shows a kick out to them and during investigation meetings prior to the NMC investigation admissions were made about both a kick and contact being made. These admissions have now been retracted and there is now a level of uncertainty as to whether contact was made from a kick.

Ms West-Hunter submitted that these amendments do not substantially change the allegations and that these amendments have been made out on the evidence that has been before all parties for some time.

Ms West-Hunter submitted that, in terms of what the word ‘attempt’ means in relation to the proposed charge, the NMC says that it is only an indication that an intention was made to kick out and it makes no assumption on the motivation for the alleged action.

In response to a question from the panel on whether any injustice is caused to you by these amendments, Ms West-Hunter said there is very little injustice as these changes make very little difference and do not change the case against you at all.

Mr Holborn, on your behalf, strongly objected to this application.

Mr Holborn questioned the reasoning for the NMC making this application if it made no substantial change to the case.

Mr Holborn submitted that you only found out about these proposed amendments today and that these amendments substantially change your approach to the hearing and placed you at a severe disadvantage.

Mr Holborn submitted that it was procedurally unfair to bring an amendment at this stage of the hearing, which, if granted, would necessitate an adjournment. He submitted that you are now in a position where you will have to change your defence and additional preparation time would be needed for this.

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

The panel considered that the amendments, as applied for, were in the interests of justice. The panel was of the view that the amendments did not substantially change the case and were changes that reflected the evidence before it. The panel noted that the NMC evidence before it had been available to all for over a year and no new evidence had been brought.

The panel took into consideration that some unfairness may be caused to you in an amendment being made at this stage. However, in the panel's view, this can be mitigated by allowing you time to consider the amendments and prepare your defence in response.

The panel therefore decided that it was appropriate to allow the amendments, as applied for, to ensure that the NMC's case was properly particularised and fully presented.

Charges as amended:

That you, a registered nurse

1) On 23 January 2024 whilst dealing with Patient A:

    a) as the nurse in charge did not ensure that the correct safety interventions were used:
    b) failed to provide junior members of staff with appropriate support and leadership to assist in the de-escalation of Patient A
    c) attempted to kick them
    d) the attempted kick by you made contact with Patient A

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

Background

You were working at Newham House for 13 years as a mental health nurse at the time of the incident. Patient A was in a heightened state which led to an incident of violence in the ward. There was an attempt made by staff to de-escalate the situation, but this failed. Patient A's behaviour continued to escalate, and you allegedly kicked out at Patient A. CCTV footage from the incident captures you performing an alleged kick.

On 24 January 2024, you were suspended from duty pending an investigation. During an investigation meeting, you admitted that you kicked Patient A and that you made contact. You later indicated that you were unsure whether this kick had made contact with Patient A and that you had only kicked out to protect yourself. Following

disciplinary proceedings, you were dismissed from your role at Newham shortly thereafter.

Decision and reasons on application of no case to answer

The panel considered an application from Mr Holborn that there is no case to answer in respect of charge 1 in its entirety. This application was made under Rule 24(7) of the NMC Fitness to Practise Rules 2004. He submitted that this application falls under the second limb of the *Galbraith* test (R v Galbraith [1981] EWCA Crim J0519-1), set out below:

> *"That there is some evidence, but evidence which, when taken at its highest could not properly result in a fact being found proved against the nurse."*

Mr Holborn submitted that the evidence supplied by the NMC for this case and examination-in-chief was notably limited:

> *'In this case the allegations are based upon 26 seconds of CCTV, documentary evidence and one witness and the case has now been completed. The Charges have been amended several times and the Registrant submits that the way the case has progressed has added to her [PRIVATE]. Witnesses to this incident were not called by the NMC to give oral in person evidence, and the Panel has required extra documentation on occasion. Of note the Safety intervention policy now seen by the panel has useful general guidelines which highlights the need to have staff highly trained and for staff to protect service users from harm as well as the right to self-defence. There is a notable absence of evidence needed to back up the allegations made and such evidence that has been provided involves a witness with limited experience of the task allotted leading to weaknesses in conclusions and process.'*

Mr Holborn provided written submissions examining each sub-charge of Charge 1, respectively outlining why each fails under the *Galbraith* test.

Mr Holborn submitted that this is a very important case and that the charges against you are very serious. He informed the panel that you love your job, and that although disputing the charges, you are taking the allegations seriously and wish to deal with the matter in the most professional manner possible.

Mr Holborn reiterated that there is insufficient evidence put forward by the NMC to prove the allegations made, and invited the panel to find no case to answer in respect of charge 1 in its entirety.

In relation to this application, Ms West-Hunter submitted that the panel has to consider the nature and strength of the evidence and determine whether it can be relied upon to find the facts proved, as per the second *Galbraith* limb. She submitted that the panel must determine whether the facts could be found proved. She submitted that the second limb of *Galbraith* simply does not apply in this case.

Ms West-Hunter submitted that objective facts are shown by contemporaneous documents and CCTV footage, which the panel has before it. She submitted that, in light of this, there is a case to answer in respect of charge 1 in its entirety.

In relation to the CCTV, Ms West-Hunter submitted that this shows Patient A behaving violently and kicking out towards members of staff. She outlined that members of staff can be observed retreating from this incident, while you are seen kicking out towards Patient A. Ms West-Hunter submitted that this is not an instinctive leg raise. She submitted that your leg appears to be kicking out intentionally.

In addition to CCTV, Ms West-Hunter submitted that there is the chronology of your own account, as evidenced in the contemporaneous documents and corroborated by Witness 1 who conducted interviews with you after the incident. You were interviewed, and when asked to explain the incident in your own words, you said that Patient A tried to kick you, and you kicked Patient A to stop her. Ms West-Hunter submitted that, in this interview, when asked if your kick made contact, you said yes. You also made comments that other staff members tried to be less restrictive and back off. You described your actions as inexcusable and said that you were in shock

by your actions. Ms West-Hunter submitted that this admission was in a meeting forming part of the formal investigatory process.

Ms West-Hunter submitted that you were suspended from your employment, demonstrating that this was clearly a serious matter.

Ms West-Hunter submitted that you said in the meeting that you had not reacted by kicking a patient in any other instances. She submitted that this suggested that you most likely knew this was the incorrect way of dealing with patients in your care. She informed that panel that you said, in that meeting, *"God knows why I did that"* and that you *"felt threatened".* When asked how you would deal with the situation again, you said *"certainly wouldn't assault her",* and that you *"would move away."*

Ms West-Hunter submitted that there was a clear alternative to responding to Patient A with violence, and this is what is seen in the CCTV footage which is demonstrated by other members of staff who are seen moving away.

Ms West-Hunter submitted that, by kicking out at Patient A, you risked escalating the situation further, which put Patient A and other staff members at risk of potential harm. She submitted that Witness 1 highlighted the proper de-escalation process, and he noted that kicking out at Patient A was neither proportionate nor necessary. A reasonable approach would have been to retreat inside and close the door.

Ms West-Hunter submitted that, in respect of charge 1(a), this also extends to your actions during the incident. She indicated that the actions undertaken by you were not in line with correct safety interventions. She submitted that this evidence is contained within the CCTV footage and corroborated by the live evidence of Witness 1.

Ms West-Hunter submitted that, in light of all the above, there is sufficient evidence before the panel to find that there is a case to answer in relation to each and every allegation.

The panel took account of the submissions made and accepted the advice of the legal assessor who referred the panel to DMA-6 of the NMC Guidance and 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 considered both limbs of the *Galbraith* test, which stipulates:

1. There is no evidence; or
2. There is some evidence, but evidence which, taken at its highest, could not properly result in a fact being found proved against the nurse.

Charge 1(a)

The panel determined that there is no case to answer in relation to this sub-charge.

In making its decision, the panel considered the *Galbraith* test and the NMC guidance. It considered the evidence presented within the NMC's case. It took into account Witness 1's statement and his live evidence. The panel was of the view that this evidence was plausible. The panel also took into account the 26 second CCTV footage, hearsay evidence in the form of contemporaneous accounts of the incident, and the formal investigation meeting minutes.

The panel took into account that the charge stipulates that you *"did not ensure that…",* which the panel interpreted to mean that you had a duty to do so. Whilst the panel acknowledged that you were in fact the nurse in charge of the ward at the material time, there is no evidence before it to suggest you were the nurse in charge of the incident with Patient A. On the contrary, the panel had evidence before it in the form of contemporaneous meeting minutes that shows that Ms 4 was the nurse in charge of dealing with this incident.

There is also evidence before the panel that suggests you were not present at the start of the incident. Additionally, there is no evidence before the panel that, as the nurse in charge of the ward, it was your responsibility to ensure that safety interventions were in place and used. Ms 4 was a nurse and was managing the incident prior to your involvement. The Restraint and Violence Reduction Policy (the policy) does not delineate any responsibility to any seniority in the event of such an incident. The panel also took into account Witness 1's live evidence, who outlined that any member of staff who is competent and confident in safety interventions could have taken charge, which includes HCA staff.

The panel took into account the wording of the charge, namely that *"did not ensure"* suggests a failure on your behalf. However, the panel noted that there is insufficient evidence to show that there was a failure in this case. The only evidence before the panel is the CCTV footage and the evidence from Witness 1. Witness 1 outlined that, from his viewing of the CCTV footage, he did not see staff members using incorrect safety interventions.

The panel took into account that Witness 1, in his live evidence, was not critical of any safety interventions employed by staff up until the point of the alleged kick. There is also no evidence before the panel which suggests that the members of staff were not using the correct safety interventions. Witness 1 informed the panel that Patient A was already restrained by members of staff, and he had no concerns regarding their actions.

The panel did not accept Ms West-Hunter's submission that this charge also applies to interventions employed by you, as there is no evidence to support that this was your responsibility. Your own actions and role in this incident are also adequately addressed by charges 1(c) and 1(d).

The panel was of the view that there is no evidence to support a finding of fact.

Charge 1(b)

The panel determined that there is no case to answer in relation to this sub-charge.

In making its decision, the panel considered the *Galbraith* test and the NMC guidance. It considered the evidence presented within the NMC's case. It took into account Witness 1's statement and his live evidence. The panel was of the view that this evidence was plausible. The panel also took into account the 26 second CCTV footage, hearsay evidence in the form of contemporaneous accounts of the incident, and the formal investigation meeting minutes.

The panel took into account that the CCTV footage has no commentary, and there is nothing to suggest within that footage, what support, if any, was given verbally. The panel, from that footage, can only see what actions were carried out.

The panel also took into account that, within Witness 1's live evidence and written statement, he did not give evidence to suggest that you failed to provide proper support and leadership during the incident. He outlined that no one else in that situation should come in and delegate tasks, as Ms 4 was already the nurse in charge of the unfolding incident. Witness 1 outlined that possible alternative action would have been your non-involvement, and for you to retreat and close the door. This, in the panel's view, would be contrary to providing appropriate support and leadership.

Further, the panel noted that there was no evidence or criticism within the contemporaneous meeting minutes with interviewed staff members who were present, that you failed to provide any support.

The panel was of the view that there is no evidence to support a finding of fact.

Charge 1(c)

The panel determined that there is a case to answer in relation to this sub-charge.

In making its decision, the panel considered the *Galbraith* test and the NMC guidance. It considered the evidence presented within the NMC's case. It took into account Witness 1's statement and his live evidence. The panel was of the view that this evidence was plausible. The panel also took into account the 26 second CCTV footage, hearsay evidence in the form of contemporaneous accounts of the incident, and the formal investigation meeting minutes.

The panel took into account that there is some evidence of a physical act which is seen in the 26-second CCTV footage. The panel also considered that contemporaneous interviews conducted shortly after the incident contains your accounts of the incident. In these accounts, you outline your physical actions and response to the incident.

The panel was of the view that there has been sufficient evidence provided that a properly directed panel could find this charge proved. It was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Charge 1(d)

The panel determined that there is a case to answer in relation to this sub-charge.

In making its decision, the panel considered the *Galbraith* test and the NMC guidance. It considered the evidence presented within the NMC's case. It took into account Witness 1's statement and his live evidence. The panel was of the view that this evidence was plausible. The panel also took into account the 26 second CCTV footage, hearsay evidence in the form of contemporaneous accounts of the incident, and the formal investigation meeting minutes.

In the contemporaneous interview, you initially said that you did physically kick out at Patient A, and that you believed that you made contact with her by doing so. The panel acknowledged that, while other witnesses to the incident were unsure and did

not know whether you made contact with Patient A, this does not contradict your initial account of the incident.

The panel was of the view that there has been sufficient evidence provided that a properly directed panel could find this charge proved. It was not prepared, based on the evidence before it, to accede to an application of no case to answer. What weight the panel gives to any evidence remains to be determined at the conclusion of all the evidence.

Decision and reason 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 Ms West-Hunter on behalf of the NMC and by Mr Holborn on your behalf.

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

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

- Witness 1: Clinical Ward Manager at Cygnet Healthcare.

The panel also heard evidence from you under affirmation.

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

The panel only considered charges 1(c) and 1(d) due to its earlier finding of no case to answer in relation to charges 1(a) and 1(b).

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

Charge 1(c)

> "1. That you, a registered nurse on 23 January 2024, whilst dealing with Patient A:
>
> c) attempted to kick them."

This sub charge is found proved.

In reaching this decision, the panel took into account the 26-second CCTV footage, the written statement and live evidence of Witness 1, your own evidence under affirmation, and contemporaneous records of meetings, including fact-finding meetings with three members of staff who were present during the incident.

The panel acknowledged your explanation that the movement to kick out was non-intentional, as a means of protecting yourself. You explained to the panel, during the course of your live evidence, [PRIVATE].

The panel took into account that the CCTV footage shows you with your leg raised and determined that the movement is two-pronged and shows an attempted kick.

The panel noted that, at the time of the investigations, you made some admissions that you did kick Patient A. You checked the written records of the typed notes of these meetings, amended them, and signed them. You did not, in any of these accounts, outright deny kicking Patient A. In the disciplinary meeting notes for the interview which took place on 26 April 2024, you said:

> *'She went to kick me twice…I should have back (sic) away… I didn't… stepped forward and kicked out.'*

The panel concluded that the two meetings between yourself and Witness 1 are the most contemporaneous documents, are consistent and, in the panel's assessment, therefore likely to be reliable. The passage of time has changed your evidence regarding the actions you have taken, but you were consistent in your accounts at the time of the investigation meetings.

In light of the above, the panel concluded that you did attempt to kick Patient A.

The panel acknowledged your motivation of the attempted kick, [PRIVATE].

The panel finds this sub charge proved.

Charge 1(d)

> "1. That you, a registered nurse, on 23 January 2024, whilst dealing with Patient A:
>
> d) the attempted kick by you made contact with Patient A."

This sub charge is found NOT proved.

In reaching this decision, the panel took into account the 26-second CCTV footage, the written statement and live evidence of Witness 1, your own evidence under affirmation, and contemporaneous records of meetings, including fact-finding meetings with three members of staff who were present during the incident.

The panel noted that your initial reaction following the incident was to ask whether Patient A kicked you, and whether you kicked her. At a fact-finding meeting on the 29 February 2024, you indicated that you kicked and made contact with Patient A.

> *'She went towards me aggressively so I tried to stop her coming further towards me and I kicked her to stop her advancing toward me.'*

The panel took into account the contemporaneous disciplinary meeting between yourself and Ms 1 on 26 April 2024. It noted that you admitted to the kick, but

“believed” that the kick made contact with Patient A. When asked if you made contact with Patient A in the interview, you expressed doubt and could not say for definite whether contact took place:

‘I thought I did at the time…I asked…did “I kick her?” “What did you see?”’

During your live evidence at this hearing, when asked whether you made contact with Patient A, you responded that you still do not know, and described the incident as *“a haze.”* You told the panel that you asked your colleagues *“over and over”* if you kicked Patient A, but no one saw whether contact was made.

The panel took into account the meeting minutes with Ms 2, Ms 3, and Ms 4 who were present during the incident. All three saw your leg raise to kick out, but could not confirm whether you had made contact with Patient A.

The panel was informed that a body map of Patient A after the incident had no recorded marks found on Patient A.

The panel took into account the CCTV footage, which shows you kicking out at Patient A, but does not show whether there was contact. Patient A is seen recoiling back from the action, but this could also be a result of the shock of what had happened, namely a health care professional kicking out at her. The panel concluded that the CCTV footage is therefore inconclusive in respect of whether contact was made with Patient A.

The only evidence which supports finding this sub charge proved consists of your own admissions in relation to an incident in which you were understandably very upset and wishing to cooperate with the investigation. In the panel’s judgement, this evidence is outweighed by the remarkable absence of any evidence from the surrounding witnesses, that contact was made. Three other professionals were present, none of whom concluded that your leg made contact with Patient A. CCTV evidence is inconclusive. Furthermore, it is likely that if you had kicked Patient A, there would be some physical indication that you had done so when she was carefully examined shortly after the incident. The panel concluded that it is probable

that you did not make contact with Patient A and therefore charge 1(d) is found not proved.

As such, the panel determined that the NMC has failed to discharge the burden of proof in relation to this sub charge, and finds it not 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 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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms West-Hunter invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The NMC code of professional conduct: standards for conduct, performance and ethics' (the Code) in making its decision.

Ms West-Hunter identified the specific, relevant standards where your actions amounted to misconduct. She outlined that your conduct breached the NMC Code, specifically: 1.2, 4, 19, 19.4, and 20.9 of the Code.

Ms West-Hunter submitted that your conduct fell far beneath the standards of nursing professionals. She submitted that, by attempting to kick Patient A, you were neither prioritising patient safety, nor the safety of your colleagues. By kicking out at Patient A, you risked aggravating Patient A further and escalating the situation.

Ms West-Hunter submitted that, in your evidence, [PRIVATE].

Ms West-Hunter invited the panel to make a finding of misconduct in relation to the charge found proved. She reiterated the seriousness of attempting to kick a vulnerable patient, and submitted that this is made clear by your own shock at your conduct.

Mr Holborn provided written submissions outlining why your conduct in the sub charge found proved does not amount to misconduct:

> *'Contextual Factors*
> *3.1. The proven conduct relates to a single attempted instinctive reaction during a highly stressful incident*
> *involving:*
> *3.1.1. A violent patient in a state of crisis.*
> *3.1.2. An escalating incident with multiple staff failing to regain control.*
> *3.1.3. Ms. Fiske being cornered and fearful for her safety.*
> *3.1.4. [PRIVATE]*
> *3.2. The Registrant submits that her action was [PRIVATE] motivated by self protection, was reflexive, and not intended to cause harm or even intentional.*
> *4. Reflection and Insight*
> *4.1. Ms. Fiske has demonstrated significant remorse, insight, and personal accountability, including:*
> *4.1.1. Immediate self-reporting and engagement with the investigation.*
> *4.1.2. Empathy towards Patient A*

4.1.3. Acknowledgement of the incident and its impact.

4.1.4. Participation in updated training and reflection.

4.1.5. [PRIVATE]

5. Public and Professional Standards

5.1. While it is accepted that a nurse kicking at a patient may fall below the standard expected, the Panel

must also consider:

5.1.1. The unique circumstances in which the conduct occurred;

5.1.2. The absence of harm;

5.1.3. The lack of deliberate malice;

5.1.4. The risk profile going forward'

He emphasised that you were and still are *"horrified"* by your actions. He submitted that your action in the sub charge found proved was instinctual, you were not in control, and were confused by your action. He said that the action in the sub charge found proved was your reaction to Patient A's actions and did not amount to misconduct.

Submissions on impairment

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

Ms West-Hunter submitted that the first three limbs of the *Grant* test are engaged in this case. She invited the panel to find you currently impaired.

Ms West-Hunter submitted that, [PRIVATE] the panel needs to consider the extent to which you have addressed this. She submitted that the panel should also consider whether there are attitudinal issues, given your adaptation and changing of stories from your previous accounts.

Mr Holborn provided written submissions outlining the reasons that your practice is not currently impaired. In these written submissions, he outlined that there is a very low risk of repetition as this was a one-off incident in a rare context. He submitted that you demonstrated insight and remorse, and that you have *"accepted responsibility and reflected deeply."*

In terms of current risk to the public, Mr Holborn submitted that there is none, as you have not demonstrated a pattern of unsafe behaviour. Mr Holborn submitted that a finding of impairment is not necessary on the ground of public interest as you have maintained and upheld public confidence in the nursing profession through transparency and candour.

Mr Holborn submitted that you are engaging with the NMC process. He submitted that you have been cooperating and reflecting on your actions. He reiterated that your actions were not intentional. Mr Holborn invited the panel to find your practice not currently impaired.

The panel accepted the advice of the legal assessor. He advised that a breach of professional duty must be serious, if it is to amount to misconduct. In relation to impairment, he quoted from *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 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

4 Act in the best interests of people at all times

20 Uphold the reputation of your profession at all times
***To achieve this, you must**:*

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. However, the panel was of the view that this is a serious charge which could have led to a patient suffering harm and the public losing confidence in the nursing profession.

There is no justification for attempting to kick a vulnerable mental health patient, even in the context of this incident. There were other avenues to de-escalate the situation. The CCTV footage showed that there were many other staff members present at the time, who were attempting to de-escalate the situation without kicking or using force with Patient A.

Whilst the panel acknowledged your account that this was a defensive reaction [PRIVATE], it was of the view that this was nonetheless a serious departure from the professional standards expected by a registered nurse. The panel also took into account that violence and aggressive behaviour escalating, like this situation, are likely to be frequent occurrences that you may experience in your role as a mental health nurse.

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

Decision and reasons on impairment

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

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. Nurses 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. At 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.'*

At 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;'*

The panel concluded that limbs a), b) and c) of the *Grant* test were engaged in this case. Your misconduct, namely attempting to kick Patient A, put Patient A, your colleagues, and yourself at unwarranted risk of harm. By attempting to kick Patient A, your misconduct breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel went on to consider whether the misconduct is remediable. It was of the view that it is remediable but concluded that you have not provided strong enough evidence of remediation and reflection to mitigate the risk of harm and repetition.

The panel considered the reflective piece provided by you, in which you demonstrate remorse for your conduct. However, the panel concluded that your insight into your actions was limited. You did not demonstrate how you can prevent the conduct in the sub charge found proved from recurrence in the future. [PRIVATE]. The panel also noted that you did not provide character references from current employers or testimonials.

As you outlined in your live evidence, incidents like these occur often given the nature of your role as a mental health nurse, and the nature of the ward on which you work. Therefore, withdrawing may not always be an option, and there may be scenarios where you are the senior nurse in charge during similar type incidents. While you indicated that this was the first time you reacted in this way, a crisis situation that evokes this [PRIVATE] is likely to happen again. The panel was not satisfied that [PRIVATE], and as such, due to a lack of supporting evidence, could not be reassured that you will not respond the same way in the future.

The panel therefore determined that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is also required. Members of the public would be very concerned to learn that a finding of impairment were not made in this case, given the nature of the misconduct. Attempting to kick a vulnerable mental health patient is very serious, and public confidence in the profession would be undermined if a finding of impairment were not made. The panel 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 suspension order for a period of 6 months with review. The effect of this order is that the NMC register will show that your registration has been suspended.

Submissions on sanction

Ms West-Hunter informed the panel that in the Notice of Hearing, the NMC had advised you that it would seek the imposition of a striking off order if it found your fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submitted that a 9-month suspension order is more appropriate in light of the panel's findings.

Ms West-Hunter provided written submissions for the sanction stage.

Ms West-Hunter submitted that the most appropriate and proportionate order is a 9-month suspension order.

Ms West-Hunter submitted that there is evidence of attitudinal concerns given your change in accounts and lack of consistency. She submitted that you have demonstrated limited insight into the incident in your misconduct.

Ms West-Hunter submitted that, in your live evidence, you were unable to provide cogent answers as to how you will act differently in the future to prevent repetition of the conduct of the kind found proved.

Ms West-Hunter submitted [PRIVATE].

Ms West-Hunter submitted that there is a risk of repetition in the case in light of the above. She submitted that your conduct was not at the lower end of the spectrum and there is a risk of harm to the public.

Ms West-Hunter submitted that no further action, a caution order, and a conditions of practice order is neither appropriate nor proportionate in light of the public protection concerns and risk of repetition. She submitted that the misconduct in this case cannot be addressed through retraining, given the instinctual nature of the act and [PRIVATE]. She reiterated that there are attitudinal concerns, which are difficult to remediate and address through conditions.

Ms West-Hunter submitted that the most appropriate and proportionate sanction is a suspension order for a period of 9 months. She submitted that this is a serious incident of misconduct, and attempting to kick a vulnerable mental health patient is very serious. She submitted that this is a *"never"* event, that there were other avenues to de-escalate the situation, and that this was a serious departure from the professional standards expected of a nurse.

Ms West-Hunter submitted that the public protection and public interest cannot be met through any lesser sanctions.

Mr Holborn submitted that you fully accept the seriousness of the misconduct. He submitted that a caution order is the most appropriate order.

Mr Holborn submitted that your conduct during the incident was not intended. He submitted that this was a defensive and instinctive reaction to the situation, and was in no way premeditated.

Mr Holborn submitted that your nursing profession is very important to you, and you are willing to continue to cooperate.

Mr Holborn submitted that a suspension order would be inappropriate and disproportionate. He reminded the panel that the least restrictive order should be considered.

Mr Holborn submitted that conditions of practice can adequately address the misconduct, if the panel decide that a caution order is not appropriate in this case.

Mr Holborn submitted that you had the best intentions, namely to ensure the safety of those around you and Patient A. He submitted, that while this was a serious incident and you kicked out, you did so without intent. There was no element of premeditation and this was a reaction. Mr Holborn submitted that your immediate reaction was one of regret and concern.

Mr Holborn referred the panel to your reflection, dated September 2024, which outlines your feeling of shame and guilt, and the impact that your conduct had on Patient A. He submitted that you show empathy for the patient and reflected on your conduct. Mr Holborn submitted that you have been open and honest in your accounts and evidence. Your answers have been neither rehearsed nor polished.

Mr Holborn submitted that there is no evidence of deep seated and harmful attitudinal problems. Mr Holborn submitted that training in relation to stressful situations involving violence can be adequately addressed through conditions. He submitted that you have indicated that you will respond positively to training. You have looked at the requirements to retrain in the area of restraint with difficult patients.

Mr Holborn referred the panel to several positive testimonials provided by you to be considered at the sanction stage of this hearing. In these testimonials, you are described as a valued team member and capable nurse. He submitted that this was a one-off, isolated incident in an otherwise long and unblemished professional history. He submitted that you have never previously engaged in inappropriate conduct.

Mr Holborn submitted that, in light of the context and mitigation in this case, a caution order would adequately address the public protection and public interest and mark the misconduct.

The panel accepted the advice of the legal assessor, who referred the panel to the NMC Sanction Guidance (SG).

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:

- Physical act of attempted violence against a patient which put the patient at risk of suffering physical and psychological harm.
- Conduct involving a vulnerable mental health patient who was in a state of crisis.
- [PRIVATE].

Whilst the panel acknowledges that your account of the incident has changed, it concluded that this was not an attitudinal issue, as this was a short, stressful incident about which you immediately sought to be candid and forthcoming.

The panel also took into account the following mitigating features:

- Single, one-off incident of misconduct against a lengthy period working as a mental health nurse.
- Some insight and understanding of the misconduct.
- Reported the incident immediately.
- Demonstrated remorse and duty of candour at an early stage.
- [PRIVATE].

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; and*
- *The conditions will protect patients during the period they are in force.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the misconduct in this case. The panel concluded that, as you have not provided supporting evidence [PRIVATE] in a way that reduces the risk of repetition, there are no conditions that can be formulated to protect the public and meet the public interest.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems; and*

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

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case.

The panel considered that this order is 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.

The panel determined that a suspension order for a period of 6 months with review was appropriate in this case to give you time to further reflect and develop your insight. [PRIVATE].

At the end of the six month period of suspension, another Fitness to Practise panel will review the order. At the review hearing, the panel may revoke the order, it may continue the order, or it may replace this suspension order with another substantive order.

The panel acknowledged the positive testimonials provided by you at the sanction stage of the hearing. It also acknowledged that this was an isolated incident in an

otherwise unblemished career. The positive testimonials speak to your abilities, and that you are a good nurse. [PRIVATE].

The panel also acknowledged your reflections, which did not sufficiently address the impact that your misconduct had on public confidence in the nursing profession, and your colleagues. The panel determined that the six-month suspension order would allow you to obtain and provide this evidence in advance of a review hearing. Therefore, any future panel reviewing this case would be assisted by:

- A fully insightful and reflective piece which addresses how your actions impacted the nursing profession.
- [PRIVATE]

This will be confirmed to you in writing.

Interim order

As the suspension 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 suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms West-Hunter. She submitted that an interim suspension order is the most appropriate order, and will adequately protect the public and meet the public interest during the 28-day appeal period. Ms West-Hunter submitted that an interim suspension order is also in your interest [PRIVATE].

Mr Holborn opposed the application for an interim suspension order. He submitted that you would adhere to any interim orders put in place on your practice but submitted that there is no change to the risk to the public safety in the interim.

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 fact found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

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

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

That concludes this determination.