Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 1 September 2025 – Tuesday 16 September 2025

Virtual Hearing

Name of Registrant:	**Gregory David Higgins**
NMC PIN:	90D0089S
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health – 7 July 1993
Relevant Location:	Scotland
Type of case:	Misconduct
Panel members:	Patricia Dion Richardson (Chair, lay member) Sabrina Sheikh (Lay member) Chloe McCandlish-Boyd (Registrant member)
Legal Assessor:	Ian Ashford-Thom
Hearings Coordinator:	Fabbiha Ahmed
Nursing and Midwifery Council:	Represented by Safeena Rashid, Case Presenter
Mr Higgins:	Not present and not represented
Facts proved:	Charges 1a, 1b, 1c, 2, 3, 4a, 4b, 4c, 4d, 4e, 4f, 4g, 4h, 4i, 4j, 5, 6a(i), 6a(ii), 6b(ii), 6b(iii), 6c
Facts not proved:	Charges 1d, 4k, 6b(i), 6b(iv)
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 Mr Higgins was not in attendance and that the Notice of Hearing letter had been sent to Mr Higgins' registered email address by secure email on 31 July 2025.

Ms Rashid 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 that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Higgins right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Higgins

The panel next considered whether it should proceed in the absence of Mr Higgins. It had regard to Rule 21 and heard the submissions of Ms Rashid who invited the panel to continue in the absence of Mr Higgins. She submitted that Mr Higgins had voluntarily absented himself from the hearing. Ms Rashid also submitted to the panel that the NMC are due to call several witnesses who have been warned to give live evidence. She submitted that in light of this the panel should proceed in the absence of Mr Higgins.

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)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mr Higgins. In reaching this decision, the panel has considered the submissions of Ms Rashid and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 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 Mr Higgins;
- Mr Higgins has informed the NMC that he has received the Notice of Hearing and confirmed he is content for the hearing to proceed in their absence;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- A number of witnesses have been warned to give live evidence and attend eight days of the hearing
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- 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 Mr Higgins in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address he will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on his 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 Mr Higgins decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Details of charge

That you, a registered nurse:

1. Between 2018 to August 2022, you failed to maintain professional boundaries with Patient A in that you:

    a. On one or more occasions you took Patient A shopping;
    b. Failed to discharge Patient A from your case load/[PRIVATE];
    c. On one or more occasions you visited Patient A [PRIVATE];
    d. On 7 July 2022 and/or 9 August 2022 you visited Patient A, after you had been suspended from work [PRIVATE] in October 2021.

2. Between August 2021 to October 2021 whilst Patient A was in your care, you failed to maintain professional boundaries in that you had an intimate and/or sexual relationship with Patient A.

3. Between October 2021 to 2025, you continued to breach professional boundaries, once Patient A was no longer under your care, in that you had an intimate and/or sexual relationship with Patient A.

4. Between September 2019 – 6 October 2021, you failed to maintain professional boundaries with Patient B in that you:

    a. Declined to hold appointments in the clinic when requested by Patient B;

b. On one or more occasions held meetings with Patient B in your car;
c. Gave Patient B your personal phone number;
d. Communicated with patient B using your personal phone number;
e. On one occasion, called Patient B at approximately 8.30pm via whatsapp;
f. Continued to maintain contact with Patient B after their case was closed [PRIVATE];
g. On one or more occasions agreed to store medication for Patient B;
h. On or about 18 May 2021 collected Patient B from [PRIVATE] train station;
i. On one or more occasions hugged Patient B;
j. On one or more occasions kissed Patient B;
k. Said to Patient B "you're in love with me" or words to that effect;

5. Your actions in one or more of the charges at charge 4 above were sexually motivated in that you intended to pursue a future relationship with Patient B.

6. You demonstrated poor record keeping in that you:

a. Failed to maintain clear and accurate records in respect of Patient A in that you made no entries between the following dates:
    i. 14 December 2019 to 14 January 2021;
    ii. 14 September 2019 to 12 December 2019;

b. You failed to record that you had visited Patient A on the following dates:
    i. 13 August 2021
    ii. 20 August 2021
    iii. 17 September 2021;
    iv. 24 September 2021.

c. Failed to document that you had seen Patient B on or about 18 May 2021 on their return to [PRIVATE].'

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

Background

The NMC received a self-referral on 2 September 2022 from Mr Higgins.

The charges arose whilst Mr Higgins was employed as a registered nurse by the [PRIVATE] at NHS Greater Glasgow and Clyde Health (the 'Trust'). Mr Higgins was employed as a Band 6 Community Psychiatric Nurse.

The purpose of Mr Higgins role was to provide an initial health assessment for asylum seekers [PRIVATE] attend to their mental health needs until the patient was placed into [PRIVATE]. After these patients are placed into dispersed accommodation, patients would ordinarily be discharged from the [PRIVATE] as they were registered with a General Practitioner (GP) local to their accommodation and able to access mainstream healthcare services.

Mr Higgins was suspended from duty on 6 October 2021 and investigated by the Trust for an alleged improper relationship with a vulnerable patient and because of the nature of his support that led another vulnerable patient to complain of feeling emotionally abused, taken advantage of and feelings of being trapped by the support he provided.

The panel heard and considered the submissions made by Ms Rashid on behalf of the NMC.

Decision and reasons on facts

The panel has drawn no adverse inference from the non-attendance of Mr Higgins.

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: Band 6 CPN, Nurse in Charge at the [PRIVATE]
- Witness 2: Service Manager [PRIVATE] employed by NHS Greater Glasgow and Clyde
- Witness 3: Nurse Team Leader, [PRIVATE]
- Witness 4: Head of Operations, [PRIVATE] Housing Management
- Witness 5: Service Manager of [PRIVATE], employed by NHS Greater Glasgow and Clyde
- Witness 6: Head of Safeguarding [PRIVATE]
- Witness 7: Project Worker at [PRIVATE] Glasgow City Council
- Witness 8: Specialist Occupational Therapist, employed by NHS Greater Glasgow and Clyde
- Witness 9: Women's Service manager and manager within [PRIVATE] service

- Witness 10 — Senior paralegal, Nursing and Midwifery Council

The panel did not hear live evidence from Witness 10, whose evidence was duplicated by Witness 1.

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:

1. Between 2018 to August 2022, you failed to maintain professional boundaries with Patient A in that you:
   a. On one or more occasions you took Patient A shopping;

This charge is found proved.

In reaching its decision, the panel reminded itself that all registered nurses have a professional duty to maintain appropriate boundaries at all times. In particular, the panel considered live evidence from all witnesses, who were unanimous in their view that the nature of Mr Higgins role required an enhanced level of caution due to the vulnerability of the patients in the care of [PRIVATE]. The panel determined that this placed a greater responsibility on Mr Higgins to ensure that professional boundaries were upheld at all times.

In relation to charge 1(a) the panel took into account the EMIS Records of Patient A and the provisions of the NMC ‘Code’. The panel noted that Patient A was on Mr

Higgins caseload from May 2018 to August 2022. It also considered the admission made by Mr Higgins that he took Patient A shopping. In the NHS Scotland Workforce Policy investigation process, investigation meeting notes, Mr Higgins said:

> *'Yes, there was a day I took her shopping just to get her heavy items, there are no halal shops in Easterhouse. I do that with other patients too, something I have always done.'*

The panel considered this admission made by Mr Higgins that he had taken Patient A out to do her shopping. The panel considered the evidence from the welfare check, in which Patient A stated that Mr Higgins had assisted her with carrying heavy shopping.

The panel noted that both Patient A and Mr Higgins recalled going out shopping together on this occasion. On the balance of probabilities, the panel found this charged proved.

Charge 1b

> 'b) Failed to discharge Patient A from your case load/[PRIVATE];'

This charge is found proved.

The panel determined that Mr Higgins had a duty to discharge Patient A from the [PRIVATE] caseload. The panel took into account that although there was no prescribed timeframe for discharge, Witnesses 1, 3 and 5 agreed that keeping a patient on the caseload for a period of four years was far in excess of what would ordinarily be expected once a patient has been placed into dispersed accommodation.

Witness 1 stated in her live evidence that:

> *"It is unusual to keep anyone on your books for a few months, 5 to 6 months tops during the Covid period.'*

The panel was aware that Patient A was first seen in 2018 ahead of the pandemic outbreak. There was no documented rationale as to why there was continued involvement with a patient who had been moved [PRVATE] and registered with a local GP.

The panel had regard to the EMIS record which indicated that there was no contact between Mr Higgins and Patient A from December 2019 to January 2021. The panel was of the view that Patient A should have been discharged from the caseload at this point. It noted that keeping a patient actively open on a caseload, despite a lack of engagement, was contrary to the professional standards expected within the team.

The panel was assisted by the evidence of Witness 3, who explained that where a patient remains on a caseload there must be a clear rationale recorded, including the purpose of engagement, any plan for the patient, and the associated risks. Witness 3 further stated that if there has been no engagement for over a year, Mr Higgins should have either discharged Patient A or made a referral where risks remain.

The panel accepted this evidence as cogent and credible. The panel determined that leaving Patient A on the caseload for such an extended period, without ongoing engagement, created unnecessary risk for overburdening the team's caseload. The panel further took into account the evidence from Witness 5 in that she stated that this is a 'bridging' service and is designed to provide temporary support until patients have settled [PRIVATE], not to provide long term case management.

Charge 1c

'c) On one or more occasions you visited Patient A [PRIVATE];'

This charge is found proved.

The panel had sight of documentary evidence, namely photographs of Mr Higgins' company lease car outside of Patient A's home. Witness 3 in his live evidence told the

panel that it was ‘well known’ that this was Mr Higgins’ car. When asked how he knew this was Mr Higgins’ car he told the panel that it was a company lease car and confirmed that he had checked the license plate, which matched Mr Higgins’ vehicle. The panel also considered contemporaneous interview notes from Witness 2 where Mr Higgins admits that the images put to him were of his car outside of Patient A’s home.

> *‘When asked about the dates his car was seen outside of Patient A’s home, Mr Higgins confirmed that this was his car… Mr Higgins confirmed that he was at the patients home on all of the dates listed…’*

In live evidence Witness 6 was shown images of the house and asked what she could see. She told the panel that this was Patient A’s home with Mr Higgins’ car parked outside of it.

Witness 4 explained that it was *“so unusual”* to see a team member [PRIVATE] that this presence raised concerns which were in part what led to him referring these concerns to Witness 6 as head of safeguarding.

Having considered this evidence, together with Mr Higgins’ admission, the panel finds this charge proved.

Charge 1d

> ‘d) On 7 July 2022 and/or 9 August 2022 you visited Patient A, after you had been suspended from work [PRIVATE] in October 2021.’

This charge is found not proved.

The panel found this charge not proved. The panel had regard to an email sent by the housing manager to Witness 4 that stated that he saw Mr Higgins and Patient A’s family in his vehicle on both 7 July 2022 and 9 August 2022.

The panel acknowledged that whilst this account raises concerns regarding Mr Higgins' conduct, the panel found that this charge is not proved. The panel noted that it does not have an admission from Mr Higgins before it and found no further supporting evidence to demonstrate that Mr Higgins had visited patient A's home on those occasions. The panel determined that there is no evidence that he 'visited' Patient A as opposed to having 'met' her or had 'contact' with her.

Accordingly, the panel found this charge not proved.

Charge 2

2. Between August 2021 to October 2021 whilst Patient A was in your care, you failed to maintain professional boundaries in that you had an intimate and/or sexual relationship with Patient A.

The panel found this charge proved.

The panel determined that between August 2021 and October 2021, Patient A remained on Mr Higgins' caseload. In reaching this finding, the panel had regard to the EMIS records, which disclosed notes from a visit where Patient A referred to being 'pregnant'.

The panel had sight of documentary evidence, namely YouTube video clips uploaded by Patient A featuring Mr Higgins. The panel noted that these YouTube videos were titled *"husband"* when showing Mr Higgins and *"daddy"* when featuring what appears to be Patient A's youngest child with Mr Higgins.

In oral evidence Witness 1 also confirmed the people within the videos to be Mr Higgins and Patient A. Witness 1 also confirmed that the YouTube channel name seen in this exhibit was the name of Patient A.

[PRIVATE].

It also considered that between August 2021 and October 2021 Mr Higgin's had been seen outside of Patient A's home frequently, namely on six separate occasions. The panel heard evidence from Witness 4, to whom it was reported that Mr Higgins was seen in his shorts and flip flops leaving Patient A's home. The panel determined that this was unprofessional and a definite breach of maintaining professional boundaries.

The panel determined that all the above evidence before it demonstrated clearly that on the balance of probabilities Mr Higgins had an intimate and sexual relationship with Patient A.

Charge 3

3. Between October 2021 to 2025, you continued to breach professional boundaries, once Patient A was no longer under your care, in that you had an intimate and/or sexual relationship with Patient A.

This charge is proved.

The panel applied the same rationale as in charge 2. It had sight of further evidence in the form of YouTube clips uploaded to the platform the most recent of which was January 2025. The panel was satisfied that the content of these videos portrayed a personal relationship between Mr Higgins and Patient A.

In oral evidence Witness 1 also confirmed the people within the videos to be Mr Higgins and Patient A.

Therefore, the panel was satisfied that this charge is found proved.

Charge 4a

'4. Between September 2019 – 6 October 2021, you failed to maintain professional boundaries with Patient B in that you:

a) Declined to hold appointments in the clinic when requested by Patient B;'

This charge is proved.

The panel determined that it was appropriate and proportionate for Patient B to request appointments to be held strictly at the clinic and for her request to be fulfilled. The panel had regard to Patient B's complaint form in which she outlines that:

> *'…there is something not okay going on. So, I asked the practitioner to hold the appointment in the clinic rather than in the flat. In the appointment, I tried to ask for a referral – to stop seeing him-, but he pressured me and emotionally abused me to keep seeing him. After that, the practitioner started to visit me in the flat.'*

The panel also had regard to Mr Higgins interview notes in which he stated:

> *' …she would ask for weekly appointments, I would try and encourage her to come to clinics to get her out the house she would ask me to visit her at home.'*

The panel considered the evidence of Witness 3, who said that the team had clinic space they can utilise for appointments, and that appointment locations should be agreed with the patient.

The panel determined that on the balance of probabilities that Patient B's account was more accurate. The panel also had regard to Witness 7 who said in her live evidence that Patient B requested that both matters in relation to her housing and [PRIVATE] are kept separate. The panel determined that it appears that Patient B wanted to keep these matters separate so that Mr Higgins would not know where she resided.

The panel determined that Patient B's account was consistent with her statement.

The panel found this charged proved.

Charge 4b

‘b) On one or more occasions held meetings with Patient B in your car;’

This charge is proved.

The panel had regard to Mr Higgins interview notes in which he accepts that he met Patient B in his car. He stated that:

> *‘She didn’t want me going into the building so she asked me to meet her outside so I parked outside the building and met her in the car, had nowhere else to go, asked her to come to the clinic but she wouldn’t.’*

The panel determined that such conduct was wholly inappropriate, unprofessional and amounted to a breach of standards expected of a registered nurse.

The panel also had regard to Patient B’s witness statement to Witness 8, in which she wrote:

> *‘… she didn’t feel comfortable because it was a small space, she felt pressed against the car door…’*

Further, the panel noted that Mr Higgins’ admissions and Patient B’s statement to Witness 2 in which she described the meeting in his car as *‘triggering’* when compared to a meeting held at the clinic. The panel also noted that Patient B had made a similar complaint to Witness 8 again stating that she did not feel comfortable.

In light of Mr Higgins’ admissions and the consistent evidence of Patient B, the panel was satisfied, on the balance of probabilities, that this charge is found proved.

Charge 4c

‘c) Gave Patient B your personal phone number;’

This charge is proved.

The panel had sight of the evidence before it including screenshots of a WhatsApp missed call from Mr Higgins to Patient B at 20:37, outside of Mr Higgins' working hours. This was put to Mr Higgins during his investigation interview with Witness 2 where he accepted that this was his personal phone number explaining that he had *'inadvertently given it out'* when he had problems with his work phone.

The panel also considered Patient B's statement in which she explained that prior to the pandemic she had a different contact number for Mr Higgins to the one subsequently provided to her at the start of the Covid-19 pandemic. The panel determined that the subsequent phone number was Mr Higgins personal phone number. Further to this, the WhatsApp screenshot messages between Patient B and Mr Higgins contained the contact name saved in Patient B's phone, which was saved *'Greg Nurse 2'*, which was the same contact details of the missed call. The panel determined that this indicated two separate numbers had been associated with Mr Higgins on Patient B's phone.

The panel noted that Witnesses 1, 3 and 5 all gave evidence that it was wholly inappropriate to give your personal phone number to any patient.

While the panel acknowledged that it had not itself viewed the telephone number in order to make a direct comparison, it was satisfied that there was sufficient corroborative evidence before it to establish that this was Mr Higgins personal phone number.

In light of this evidence, the panel determined that Mr Higgins had used his personal phone number to contact Patient B.

Charge 4d

'd. Communicated with patient B using your personal phone number;'

This charge is proved.

The panel applied the same rationale to this charge as it did it relation to charge 4c.

The panel had sight of screenshots of text messages from Mr Higgins to Patient B from his personal phone number. The panel determined that these screenshots were a clear indication that Mr Higgins was communicating with, and responding to, Patient B via text message.

The panel further determined that this contact represented a breach of professional boundaries expected of a registered nurse.

The panel determined that Patient B's account is consistent and more probable. The panel was therefore satisfied that this charge is proved on the balance of probabilities.

Charge 4e

'e. On one occasion, called Patient B at approximately 8.30pm via whatsapp;'

This charge is proved.

The panel had sight of the WhatsApp screenshot detailing the missed call from Mr Higgins to Patient B at approximately 8:30pm, outside of his working hours. Mr Higgins in his interview with Witness 2 confirmed that this was a call he made, however that this must have been done in error and that he would *'never contact a patient on a Saturday night'*.

The panel also had regard to the evidence from Witness 7, who stated that Patient B had complained that when asked why Mr Higgins had phoned her at 8:37pm, he had told her he was *'drinking and did silly things when drinking that he can't remember'* .The panel heard live evidence from Witness 7 which it found her to be consistent in her account.

The panel determined that the call made by Mr Higgins was intentional, and not, as Mr Higgins suggested, an error. The panel considered Patient B's account to be

more probable and reliable in that Mr Higgins called Patient B at approximately 8:30pm.

The panel was satisfied that this conduct amounted to a failure to maintain professional boundaries and finds this charge proved.

Charge 4f

> ‘f. Continued to maintain contact with Patient B after their case was closed [PRIVATE];’

This charge is proved.

The panel acknowledged that Patient B was formally discharged from the [PRIVATE] on 25 November 2019. The panel determined that this discharge amounted to Patient B’s case being formally closed and that there should have been no further contact with Patient B after this date especially as the EMIS records indicate involvement from thereon [PRIVATE].

The panel had sight of evidence that Mr Higgins was in contact with Patient B on 23 January 2020 and numerous further contact up until August 2020 including visits to her home. The panel also had sight of additional evidence, which included Mr Higgins attendance at the [PRIVATE] with Patient B on 18 May 2021 and EMIS Report demonstrating that he continued to make contact with Patient B after her case was closed.

The panel heard live evidence from Witness 5, who was consistent with her written statement in that Patient B’s case had been closed to the service nine months prior to when Mr Higgins had taken Patient B to [PRIVATE].

The panel determined that it is clear from the cogent evidence before it provided by the EMIS records, Witness 5 and the documentary evidence that Mr Higgins continued to maintain contact with Patient B after her case was closed.

Charge 4g

‘g. On one or more occasions agreed to store medication for Patient B;’

This charge is proved.

The panel heard live evidence from all Witnesses that staff should never agree to hold medication for patients.

The panel had regard to an ‘Outcome of Conduct Hearing’ letter addressed to Mr Higgins following his dismissal. The letter stated that:

> *‘In relation to storing Patient B’s medication, you were asked if this was something you did and you stated that you did not recall doing this, however you may have done this when she came back* [PRIVATE]. *You explained that you would have done this if you thought she was at risk.’*

In Patient B’s interview notes she stated that she gave the medication to Mr Higgins, and he arranged to give it back to her the following week. The panel noted that Mr Higgins does not dispute this, stating that it *‘maybe’* happened. The panel considered that this was a significant matter for Mr Higgins not to clearly recall and determined that Patient B’s account was more probable.

The panel noted that there was no identified risk which would have justified Mr Higgins holding the medication on behalf of Patient B. Mr Higgins did not suggest or record that Patient B posed a risk to herself or to others. While the panel acknowledged [PRIVATE], this was not recorded by Mr Higgins at the time, [PRIVATE]. [PRIVATE]

The panel determined that Witness 8’s evidence was consistent and corroborated Patient B’s version of events. The panel further determined that the fact that Mr Higgins took the medication and subsequently returned it to Patient B demonstrates that there was an agreement to store her medication.

Accordingly, the panel finds this charge proved.

Charge 4h

'h. On or about 18 May 2021 collected Patient B from [PRIVATE] train station'

This charge is proved.

The panel had sight of Mr Higgins' admissions in which he accepted that he collected Patient B from [PRIVATE] train station. In his written statement to the NMC, he stated:

> *'I did not maintain objectivity and keep clear boundaries and should have not collected her in my car.'*

Patient B, in her interview with Witness 2, also confirmed that Mr Higgins collected her from the station. Patient B's account was consistent with her written statement in which she stated:

'The practitioner was offering concrete support to me such as picking me up from the train station when I just moved back to [PRIVATE]*…'*

The panel also heard live evidence from Witness 5 that there is a procedure where nurses should let the [PRIVATE] know if they are transporting a patient, where they are going and if this is out of hours another staff member should also be present. In her live evidence Witness 5 told the panel that there was a massive risk to safeguarding in relation to no one at the [PRIVATE] knowing that Mr Higgins was with Patient B.

The panel determined that Mr Higgins admissions, together with the consistent evidence provided by Patient B, demonstrated that he had collected her from [PRIVATE] train station and failed to maintain appropriate professional boundaries.

Therefore, the panel finds this charge proved.

Charge 4i

'i. On one or more occasions hugged Patient B;'

This charge is proved.

The panel considered Patient B's witness statement, in which she stated that Mr Higgins hugged her when she went to see him after her phone had been stolen. Patient B also provided screenshots of text messages exchanged with Mr Higgins, in which she confronted him about the hug and kiss. The panel had sight of Mr Higgins' response, in that he apologised stating that he did not mean to offend her and acted in *'reassurance and friendship'*.

The panel noted that there was no evidence before it to show that Mr Higgins reported this serious incident to a line manager or made a document of it on the EMIS system, as would have been expected of a registered nurse.

The panel also had regard to evidence from Witness 8 who confirmed that Patient B had also told her that Mr Higgins had hugged her.

The panel determined that Patient B's account was consistent with the contemporaneous messages, her description of the interaction and Witness 8's evidence.

The panel found this charge proved.

Charge 4j

'j. On one or more occasions kissed Patient B;'

This charge is proved.

The panel applied the same rationale as in charge 4(i) and noted the circumstances as described by Patient B; in that her phone was stolen and she had gone to see Mr Higgins. Patient B provided a detailed account as what she titled *'the first incident of sexual harassment'*.

Patient B wrote in her statement that:

> *'…he holds my face with his both hands and looked at me in a strange way and then come closer and kissed me.'*

The panel carefully considered her account and determined that it was specific and consistent, supporting the likelihood that this event occurred as she described. The panel noted that Patient B was able to recall the circumstances with clarity, including the context in which she attended the clinic to see Mr Higgins and the details of the interaction that followed.

The panel determined that this level of detail would have been difficult to fabricate, and that Patient B's account is probable on the balance of probabilities.

The panel therefore finds this charge proved.

Charge 4k

> 'k. Said to Patient B "you're in love with me" or words to that effect;'

This charge is not proved.

The panel does not find this charge proved. The panel determined that the wording of this charge is specific in alleging that the words 'you're in love with me' were used by Mr Higgins. The panel considered the documentary evidence of Patient B, who stated that she had concerns regarding Mr Higgins intention and that his behaviour made her feel as though he wanted to believe she was in love with him.

The panel considered that Patient B did not provide clear evidence of these exact words used by Mr Higgins. The panel acknowledged that while Patient B's perception of Mr Higgins conduct was concerning, the panel determined that Patient B's complaint did not specifically stipulate that Mr Higgins said the words as set out in the charge.

The panel reminded itself that it must be satisfied on the balance of probabilities that the conduct alleged occurred in the specific terms of the charge. The panel determined that the evidence does not reach the burden of proof in relation to this charge.

Accordingly, the panel finds this charge not proved.

Charge 5

> '5. Your actions in one or more of the charges at charge 4 above were sexually motivated in that you intended to pursue a future relationship with Patient B.'

This charge is proved.

In relation to all the charges in charge 4 found proved, the panel carefully considered them both individually and collectively. The panel was of the view that many of these incidents occurred when Patient B was at her most vulnerable.

The panel noted the evidence that other staff members were aware of Mr Higgins behaviour which appeared to be inappropriate. The panel further considered the evidence of Witness 8, who confirmed that there was no indication that Patient B was suffering from psychosis or hallucinations at the relevant time, and that she was competent in recalling the events involving Mr Higgins.

The panel also noted that staff members at [PRIVATE] had concerns about the amount of time Mr Higgins spent with Patient B during the booking in procedure. The panel noted that there was no documented record on EMIS of the contact between Mr Higgins and Patient B during the incidents referred to in Charge 4. The panel noted that poor documentation of such incidents was indicative of having something to conceal.

The panel determined that Mr Higgins actions had the effect of blurring professional boundaries between himself and Patient B. The panel had specific regard to Witness 7 who told the panel that Mr Higgins told the staff at [PRIVATE] that he was Patient B's CPN when he was not. The panel determined that this was a clear attempt to stay involved with Patient B after she was discharged. The panel determined that in its view there is no other rationale for Mr Higgins' actions than wanting to pursue a relationship with Patient B in such circumstances.

The panel was satisfied that the conduct in Charge 4 was unlikely to have been innocent in nature. In particular, the incidents involving Mr Higgins kissing Patient B was highlighted as a significant breach of professional boundaries. When put to other witnesses, they confirmed that this behaviour was wholly inappropriate and unacceptable.

The panel noted the wider context which these incidents that took place. Mr Higgins' repeated and unrecorded interactions with Patient B, as well as the observations of inappropriate contact and excessive time spent alone with her, further undermined any suggestion that the conduct was innocent.

Accordingly, the panel determined that Mr Higgins conduct was sexually motivated and indicative of an intention to pursue a relationship with Patient B.

Charge 6ai

'6.You demonstrated poor record keeping in that you:

a) Failed to maintain clear and accurate records in respect of Patient A in that you made no entries between the following dates:

i. 14 December 2019 to 14 January 2021;

This charge is proved.

The panel saw evidence of EMIS records that indicated that Patient A was still on the caseload and notes should have been taken and recorded during this time of outcomes of consultations with the patient. The panel noted that there were no records/evidence of Mr Higgins seeing Patient A between 14 December 2019 – January 2021.

The panel was aware that Mr Higgins had access to the EMIS records, but no entries were made. The panel determined that this was concerning given that Patient A was still on the caseload for over a year with no records made. The panel further determined that Mr Higgins had a duty to keep accurate records given that Patient A was open on his caseload.

Therefore, the panel finds this charge proved.

ii. 14 September 2019 to 12 December 2019;

This charge is proved.

The panel noted that Mr Higgins last entry with regards to Patient A was on 13 September 2019 where he made a note that he would continue to provide support. However, no further entries were made until 12 December 2019.

The panel had Mr Higgins admission before it in his letter the NMC. He wrote: *'I failed to record keep'.* The panel determined that Mr Higgins takes accountability for his lack of record keeping where he failed to document the support he provided to Patient A during the period of her involvement with [PRIVATE].

Therefore, the panel finds this charge proved.

Charge 6bi

b. You failed to record that you had visited Patient A on the following dates:

i. 13 August 2021

This charge is not proved.

The panel did not find this charge proved. The panel noted that Mr Higgins did make an entry on 13 August 2021. While the panel considered that the quality of the entry was poor it was nevertheless an entry made on the record.

Accordingly, the panel determined that this charge is not proved.

Charge 6bii

ii. 20 August 2021

This charge is proved.

The panel found this charge proved. The panel noted that there was no entry made by Mr Higgins on 20 August 2021. The panel had sight of evidence that Mr Higgins' car had been seen outside of Patient A's home on this date and noted his admission in the interview notes, in which he accepted that he had visited Patient A's home.

The panel also reviewed the EMIS record and noted that there was no entry documenting this visit. The panel determined that the absence of any record in the clinical notes confirmed that Mr Higgins failed to document his contact with Patient A.

The panel therefore found this charge proved.

Charge 6biii

iii. 17 September 2021;

This charge is proved.

The panel used the same rational as in Charge 6(b)(ii) and finds this charged proved.

In light of this decision, the panel had regard to Mr Higgins' admission and the missed entry on the EMIS records. The panel was therefore satisfied that this charge is found proved.

Charge 6biv

iv. 24 September 2021.

This charge is not proved.

The panel had documentary evidence before it that noted Mr Higgins was seen on 24 September 2021 on two occasions outside of Patient A's home, namely at 10:46am and 12:48pm.

The panel noted that Mr Higgins did make an entry on 24 September at approximately 14:00.

The panel was satisfied that there is an entry on EMIS and therefore finds this charge not proved.

Charge 6c

c. Failed to document that you had seen Patient B on or about 18 May 2021 on their return [PRIVATE].

This charge is proved.

The panel found this charge proved. The panel considered the evidence of several witnesses, in particular Witness 5 as well as the admission made by Mr Higgins that he collected Patient B from [PRIVATE] train station. The panel heard consistent testimony that Mr Higgins had a duty to document all contact with patients, particularly when transporting them. Witness 5 in her live evidence in response to panel questions regarding transporting patients, said:

"If it was within working hours and someone was informed, we have a service within the outreach team and everyone knows where they are and it is never outside of hours and if it was, everything would be documented and there would be two staff there."

The panel also heard from Witness 9 who confirmed in her live oral evidence that such contact should have been documented in the EMIS records and that Mr Higgins picked up patient B when he should not have done so.

The panel determined that Mr Higgins failed to document that he had seen Patient B on or about 18 May 2021. The panel determined that Mr Higgins' failure to make an entry in the EMIS records meant that his involvement with Patient B on this occasion was undocumented, which created a greater risk in safeguarding.

The panel were of the view that accurate and contemporaneous documentation is fundamental to Mr Higgins' role.

In light of this, the panel found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Higgins' 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, Mr Higgins' fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Rashid invited the panel to take the view that the facts found proved amounted to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Ms Rashid identified the specific, relevant standards where Mr Higgins' actions amounted to misconduct and referred the panel to the following parts of the Code: 1, 1.2,1.4,2,8,8.1,8.2,8.4,10,18.4,20,20.6. She submitted that Mr Higgins' conduct in the charges found proved by the panel fell short of what was proper in the circumstances and that his actions had amounted to serious misconduct.

Ms Rashid submitted that the panel must look at any deep-seated attitudinal matters with regards to the nature of the allegations, particularly towards vulnerable women. She submitted that Mr Higgins was *"dressing up"* his true motives as a desire to help. Ms Rashid further submitted that Mr Higgins continued to have a relationship with Patient A after he was suspended, she submitted that this indicated a clear disregard to the suspension, the reason and professional boundaries. Ms Rashid further submitted that Mr Higgins' clearly does not perceive his behaviour as inappropriate.

Ms Rashid submitted that Mr Higgins' actions was not an isolated incident that involved Patient A and B but instead formed part of a wider course of conduct. Ms

Rashid submitted that Mr Higgins failed to document his meeting with the patients on several occasions and submitted that his conduct presents a significant concern and increased the potential for serious harm.

For all of those reasons, Ms Rashid submitted that Mr Higgins' conduct as set out in the charges found proved, amounted to misconduct in that he fell short of what was proper in the circumstances of a registered nurse.

Submissions on impairment

Ms Rashid 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).

Ms Rashid submitted that limbs a-c of the *"test"* is engaged, and a finding of impairment is required. Ms Rashid submitted that a finding on impairment is necessary in order to promote and maintain professional standards of conduct. She submitted that Mr Higgins' conduct represents a clear breach of those standards.

Ms Rashid acknowledged that the panel has before it documents provided by Mr Higgins, including references and a statement in clear support of his character. She submitted that some colleagues have spoken highly of Mr Higgins. Ms Rashid submitted that, despite these glowing references, none have commented specifically on his interactions with Patient A and B. She further submitted that those providing the references were not privy to the evidence that the panel has had benefit of hearing and considering.

For those reasons, Mr Rashid submitted that the panel should place limited weight when considering these references in its assessment a finding of impairment.

Ms Rashid highlighted that Mr Higgins denied many of the allegations against him and has demonstrated limited insight into his misconduct. She submitted that Mr Higgins has not made any attempt to remediate or address the concerns arising from his practice and therefore his fitness to practise remains impaired.

Ms Rashid invited the panel to find that Mr Higgins' fitness to practise is currently impaired.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

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

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

'1.2 make sure you deliver the fundamentals of care effectively

2 Listen to people and respond to their preferences and concerns

8.1 You must work with other members of the team to promote health care environments that are conducive to safe, therapeutic and ethical practice.

8.2 maintain effective communication with colleagues

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

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

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

8.6 share information to identify and reduce risk

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

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

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

13.4 take account of your own personal safety as well as the safety of people in your care

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

18.4 take all steps to keep medicines stored securely

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

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel determined that Mr Higgins breached the fundamental tenet of professionalism and that Mr Higgins' actions fell seriously short of the conduct and the standards that would be proper in the circumstances and were serious to amount to a finding of misconduct.

The panel considered that Mr Higgins was in a position of trust dealing with extremely vulnerable patients with a background of having suffered trauma. Mr Higgins' failed to discharge them from the service and to maintain contact with them over a lengthy period of time despite their care needs having been transferred to the community health care professionals. This was a serious concern putting not only the patients but also the service at risk. The panel considered his actions and motives for maintaining contact to be an extremely serious breach of his professional boundaries. The panel noted that these were not isolated incidents but formed a pattern of behaviour over a significant period of time affecting two highly vulnerable patients. Mr Higgins' failure to report and document his contact with the patients was in itself a serious departure from the standards expected and the panel was of the view was intended to enable him to pursue his motive of having and maintaining an intimate relationship with them without the scrutiny of his colleagues.

The panel determined that other members of the profession and members of the public would find Mr Higgins' actions to be deplorable.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Higgins' 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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or*

determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *…'*

The panel found that patients were put at risk and were caused emotional harm as a result of Mr Higgins' misconduct. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to acting outside the scope of his role to be extremely serious.

The panel determined that Mr Higgins demonstrated a lack of insight into his misconduct. While the panel had before it the response bundle provided by Mr Higgins, including a number of positive references from colleagues who spoke highly of him, none of these references addressed his inappropriate relationship with Patient A and his interactions with Patient B. The panel noted that Mr Higgins denied that there was any intimate relationship with Patient A, despite clear evidence of the contrary. The panel also noted that he maintained this relationship after his suspension, which it considered a matter of significant concern.

The panel acknowledged that Mr Higgins admitted to some failings, including a failure to document care appropriately and to maintain professional boundaries. However, he continued to deny the full extent of his relationship with Patient A. The panel considered that Mr Higgins' insight was limited. In particular, he did not

demonstrate an understanding of how his actions increased Patient B's vulnerability or caused her distress. The panel had regard to Patient B's statement in which she stated:

> *'Despite the fact that he helped me get through some extremely difficult periods, any progress I achieved throughout treatment has been undone and at times got worse as a result of his actions. Greg Higgins exploited me.'*

The panel took into account the evidence of Witness 5, who reviewed Mr Higgins' caseload after his suspension. Witness 5 expressed concerns that Mr Higgins intentionally retained young female patients on his caseload, even where Witness 1, had been specifically assigned to provide care to these vulnerable women. The panel found this highly concerning and considered it further evidence of attitudinal issues rather than isolated errors.

The panel found that Mr Higgins' actions demonstrated a deep-seated attitudinal concern. The panel acknowledged that whilst Mr Higgins accepted that his record keeping was inadequate, he failed to recognise the seriousness of forming and maintaining personal relationships with patients. Instead, he sought to justify his conduct by reference to his caseload and external circumstances, such as the pressure of the Covid-19 pandemic. The panel considered this explanation to have lacked accountability. The panel noted that Mr Higgins had opportunities during supervision to discuss his caseload and raise concerns but chose not to do so, instead continuing the inappropriate conduct.

The panel considered the letter written by Mr Higgins addressed to the NMC apologising for his conduct. The panel did not consider this apology to demonstrate genuine remorse either in his letter or during the internal investigation conducted by the Trust. The panel determined that Mr Higgins minimised his behaviour by stating that he had acted with 'good intentions'. The panel determined that Mr Higgins has not meaningfully reflected on his actions or their impact, particularly on vulnerable patients.

The panel considered the seriousness of the charges found proved and determined that there was very little evidence of remediation or a strengthened practice. It had no evidence of further training or certification to address this conduct. The panel determined that the charges found proved cannot be remediated, in particular, the panel was not satisfied that the breaches of professional boundaries could be addressed. The panel determined that Mr Higgins apparent preference for working with young female patients, and his tendency to create relationships that foster dependency, raised serious concern.

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 noted that Mr Higgins had not remediated his misconduct and lacks significant insight. It determined that his actions placed vulnerable patients at risk of harm and present a real risk of repetition. The panel determined, for those reasons, that a finding of impairment is necessary on both public protection and public interest grounds.

The panel determined that Mr Higgins' conduct was not an isolated incident, but rather a pattern of behaviour sustained over a number of years. The panel accepted the submissions of Ms Rashid that Mr Higgins' behaviour caused harm to patients and represented a serious breach of standards expected of a registered professional.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Higgins off the register. The

effect of this order is that the NMC register will show that Mr Higgins has been struck-off the register.

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

Submissions on sanction

The panel took into account the submissions of Ms Rashid. She invited the panel to make a striking-off order as the appropriate and proportionate sanction in this case.

Ms Rashid submitted that a significant element of this case involves sexual misconduct involving Patient A and Patient B. She referred the panel to the NMC's 'Sanctions Guidance' (SAN-2), and in particular focused on sections addressing cases of sexual misconduct.

Ms Rashid reminded the panel that, in considering sanction it must have regard to the duration of the conduct, Mr Higgins' professional relationship and position of trust in relation to those involved, and the vulnerability of the individuals subjected to the misconduct. Ms Rashid submitted that repeated or long-term behaviour, as in the charges found proved, is more likely to indicate a risk of harm. She submitted that Mr Higgins' misconduct involves abuse of power, exploitation and predatory behaviour.

In relation to Patient A, Ms Rashid submitted that Mr Higgins engaged in an ongoing sexual relationship over a period of seven years, between 2018 – 2025. In relation to Patient B, she submitted that inappropriate conduct occurred over a two year period, between 2019 – 2021. Ms Rashid submitted that this amounted to sustained and repeated misconduct involving patients.

Ms Rashid submitted that Mr Higgins was in a clear position of trust with both patients. She highlighted to the panel that although it may appear that Patient A consented to the relationship with Mr Higgins, Ms Rashid reminded the panel that this relationship commenced when Patient A was in a vulnerable position and may

not have realised the nuances of being taken advantage of. To Patient A, this was a normal relationship, however it had started entirely inappropriately. Ms Rashid submitted that there was a clear imbalance in the relationship.

Ms Rashid referred the panel to the NMC guidance that states panels should consider the guidance on sexual boundaries produced by the Professional Standards Authority (PSA). Ms Rashid, with that document in mind, referred the panel to the aggravating factors in this case.

Ms Rashid submitted that both patients were vulnerable. She submitted that the PSA highlight that abusers often target those who are vulnerable, particularly those seeking help for mental health or emotional problems. Ms Rashid submitted that Patient A did not fully appreciate the professional duty of care owed to her, and Patient B was kept within Mr Higgins' control, and he was not acting in her best interest.

Ms Rashid submitted that Mr Higgins cultivated inappropriate relationships over a period of time, as emphasised by the PSA, by, driving patients in his car, storing medication, and a continuing involvement beyond his remit. Ms Rashid submitted that Mr Higgins was cultivating an empathetic relationship with both patients, effectively grooming them.

Ms Rashid submitted that Mr Higgins used sensitive information obtained in the course of her care and encouraged Patient B to confide in him about personal matters and presented himself as a source of emotional support instead of directing Patient B to proper services. Ms Rashid submitted that Mr Higgins exploited Patient B.

Ms Rashid further submitted that, Mr Higgins' lack of documentation shows that he knew his conduct was outside of his professional boundaries and that he abused his position of trust.

Ms Rashid submitted that Mr Higgins denied many of the allegations that have been found proved and lacks insight and remediation. She submitted that the breaches of professional boundaries cannot be addressed.

Ms Rashid submitted that Mr Higgins did admit to the less serious aspects of the case, such as poor record keeping but he also tried to mitigate those through raising external factors such as lack of supervision, the workload and the Park Inn Hotel incident. Ms Rashid submitted that none of these excuse his misconduct, as support was available and not engaged with by Mr Higgins.

Ms Rashid submitted that the panel does not have before it any remediation from Mr Higgins or genuine mitigation.

Ms Rashid submitted that the only appropriate sanction is a striking-off order.

Decision and reasons on sanction

Having found Mr Higgins' 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:

- Abuse of position of trust
- Lack of insight into failings and impact of these
- Lack of remediation for clinical failings, namely, record keeping
- Lack of genuine remorse
- Misconduct occurred over a period of time
- Conduct which caused Patient B to suffer actual harm

- Disregard for the regulatory process by continuing his relationship with Patient A following suspension

The panel determined that both patients were significantly vulnerable, lacking adequate support networks. It determined that Mr Higgins created an environment in which they became dependent on him. The panel accepted Ms Rashid's submissions that Mr Higgins deliberately cultivated an empathetic relationship and, in doing so, groomed these patients.

The panel noted that Mr Higgins was involved with Patient A for seven years and Patient B for two years. It determined that this misconduct occurred repeatedly over an extended period of time and was wholly inappropriate and extremely serious. The panel considered carefully the statement provided by Patient B, which clearly and articulately recorded the emotional harm caused to her as a result of Mr Higgins' actions. The panel agreed with the submissions made by Ms Rashid as to the likelihood that Patient A may not have understood the seriousness of his actions in having a relationship with her. Her denial when asked by staff whether Mr Higgins was the father of her child suggests that she was at least aware the relationship was inappropriate.

The panel noted the references provided by Mr Higgins. However, the panel accepted Ms Rashid's submission that little, if any, weight could be given to them as they did not refer to the charges. Accordingly, the panel determined that there were no mitigating factors before it.

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 Mr Higgins' practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to*

mark that the behaviour was unacceptable and must not happen again.' The panel considered that Mr Higgins' 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 Mr Higgins' registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Higgins' registration would not adequately address the seriousness of this case and would not protect the public.

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 or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious

breach of the fundamental tenets of the profession evidenced by Mr Higgins' actions is fundamentally incompatible with Mr Higgins' remaining on the register.

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

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

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

Mr Higgins' actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Higgins' actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the

profession a clear message about the standard of behaviour required of a registered nurse.

Submissions on interim order

The panel took account of the submissions made by Ms Rashid. She invited the panel to make an interim suspension order for 18 months. She submitted that an interim suspension order would be appropriate to manage the risks identified in this case before the substantive striking off order takes effect. Ms Rashid submitted that an interim suspension order for a period of 18 months would cover the appeal period, should Mr Higgins make a decision to lodge an appeal.

The panel heard and accepted legal advice.

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 charge 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 striking-off order. The panel therefore imposed an interim suspension order for a period of 18 months on the grounds of public protection and the wider public interest, and to cover the appeal period.

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

This will be confirmed to Mr Higgins in writing.

That concludes this determination.