Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 14 April 2025 to Thursday 17 April 2025
Tuesday 22 April 2025 to Thursday 24 April 2025
Monday 23 June 2025
Wednesday 3 September 2025 to Tuesday 9 September 2025

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

Name of Registrant:	**Victoria Lynne Hinks**
NMC PIN:	17F2327E
Part(s) of the register:	Registered Nurse - Mental Health RNMH 25 June 2018
Relevant Location:	Coventry
Type of case:	Misconduct
Panel members:	Bryan Hume (Chair, lay member) Donna Green (Registrant member) Mary Golden (Lay member)
Legal Assessor:	Paul Housego Laura McGill (23 June 2025) Michael Hosford-Tanner (3 – 9 September 2025)
Hearings Coordinator:	Ifeoma Okere (14 – 17 April 2025) (22 – 24 September 2025 (23 June 2025) Rodney Dennis (3 - 9 September 2025)
Nursing and Midwifery Council:	Represented by Kir West-Hunter, Case Presenter (14 – 17 April 2025) (22 – 24 September 2025 (23 June 2025) Jamie Perriam (3 – 9 September 2025)
Miss Hinks:	Present and unrepresented
Offer no evidence:	Charge 2

Facts proved:	Charges 1(a)(i), 1(a)(ii), 1(a)(iii), 1(a)(iv), 1(b)(i), 1(b)(ii), and 1(b)(iv)
Facts not proved:	Charge 1(b)(iii)
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (18 months) with review**
Interim order:	**Interim conditions of practice order (18 months)**

Decisions and Reasons on the Application to Adjourn to Tuesday 15 April 2025

Ms West-Hunter, on behalf of the Nursing and Midwifery Council (NMC), made an application to adjourn the hearing until Tuesday 15 April 2025. [PRIVATE]. Ms West-Hunter stated that the NMC was actively seeking clarification regarding her availability later in the week. [PRIVATE].

Ms West-Hunter further submitted that you had provided additional documentation to the NMC the previous week, and that the NMC required time to review those materials and determine their relevance and admissibility. Among these materials were references to a police report and a Local Authority Designated Officer (LADO) report. Ms West-Hunter stated that, as external counsel, she was not involved in the internal disclosure process and could not confirm whether the NMC held the LADO report or whether a disclosure decision had been made in respect of it. She confirmed that enquiries were being made with the relevant review lawyer.

Ms West-Hunter submitted that an adjournment until the following morning was necessary to:

- Make further contact with Witness 2 to determine [PRIVATE] and likely availability.
- Clarify the status of the LADO document and any other potentially disclosable material.
- Enable the reviewing lawyer to assess the documents recently submitted by you.
- Continue efforts to confirm the availability of Witness 1, who had indicated she was unavailable the following day.

Ms West-Hunter also submitted that it was in the interests of justice for the NMC to be afforded a short period of time to undertake the necessary enquiries and review the newly submitted documentation before proceeding further.

You informed the panel that you would remain available throughout the day to assist with any developments or communications that might arise in relation to witness availability or disclosure issues.

The panel accepted the advice of the legal assessor.

The panel considered the application to adjourn, the grounds put forward by Ms West-Hunter, and your submissions in support. The panel was mindful of its duty to ensure that the proceedings were conducted fairly and in accordance with the principles of natural justice.

The panel took into account that Witness 2's evidence was material to the case and that her current unavailability, [PRIVATE], warranted further enquiries before a decision could be made regarding how the case should proceed. The panel also noted that there were outstanding matters relating to disclosure, including the status of the LADO report, and that additional time was needed to review documentation submitted by you.

The panel determined that it would not be fair or appropriate to proceed substantively with the hearing at this stage. Accordingly, the panel granted the application and adjourned the hearing until 10:00am the following day, with a view to reconvening and reviewing the progress of the matters raised.

The panel determined and directed that any material developments concerning the availability of Witness 1 and Witness 2, or any further disclosure issues, be brought to the panel's attention at the next sitting.

Details of charge

That you, a registered nurse,

1) On 20 September 2023,

    a) Used force against Patient A in that you:

        i) Used a second sternum rub (rubbed your fist against Patient A's chest) when not clinically justified

        ii) Held the Patient A's neck/lower jaw (mandibular movement) when not clinically justified

iii) Placed your forearm/hands around Patient A's throat

iv) Moved Patient A's head to the right while in floor holds on more than one occasion

b) Aggravated Patient A in that you:

i) Shouted at/argued with Patient A

ii) Entered Patient A's personal space causing them to step back

iii) Said that you were going to lose your "fucking shit" or words to that effect

iv) Returned to the seclusion room on more than one occasion when told not to

2) Your conduct in Charge 1a bruised Patient A.

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

Background

You were employed as a Clinical Team Leader and registered nurse at [PRIVATE] ("the Hospital"), [PRIVATE], from 14 June 2021 until your dismissal on 5 January 2024. The charges in this case relate to your conduct on 20 September 2023, during your employment at the hospital.

On that day, you were involved in an incident concerning Patient A. You had been tasked, along with other staff members, to assess whether Patient A could be granted escorted leave. The decision was made not to facilitate the leave, and you communicated this to Patient A, who was in an emotionally heightened state at the time.

Following this, Patient A became physically aggressive, punching you in the face and grabbing your hair for a prolonged period. Other staff intervened, and you applied a sternum rub pain compliance technique to Patient A's chest in order to release her

grip. This initial sternum rub is not the subject of any charges and was deemed appropriate and proportionate by the hospital during its internal investigation.

Patient A was subsequently taken to the seclusion room where she remained distressed. Close-circuit television (CCTV) footage later showed that while Patient A was in seclusion, you applied two further pain compliance techniques: a mandibular hold to her neck and lower jaw, and what was described as a second sternum rub. These were alleged to have been used without clinical justification and form the basis of charges 1(a)(i) and 1(a)(ii).

It is also alleged that during this period you placed your forearm and/or hands around Patient A's throat, as set out in charge 1(a)(iii), and moved her head to the right on more than one occasion while in a floor hold, as set out in charge 1(a)(iv).

In addition, it is alleged that you aggravated the situation by shouting at or arguing with Patient A, as set out in charge 1(b)(i); entering her personal space and causing her to step back, as detailed in charge 1(b)(ii); using language to the effect of *"I'm going to lose my fucking shit*," as referenced in charge 1(b)(iii); and returning to the seclusion room on more than one occasion after being instructed not to do so, as set out in charge 1(b)(iv).

The Hospital's investigation concluded that while the initial sternum rub was appropriate, the subsequent techniques and elements of your behaviour were not consistent with hospital policy, processes, or values. You were expected to hand over to another nurse after being assaulted, but you failed to do so and remained present in the seclusion room during the ongoing efforts to de-escalate the situation. It was observed that your body language appeared intimidating, lacked empathy, and contributed to Patient A's continued distress.

As a result of the incident and the findings of the Hospital's internal investigation, your employment was terminated on 5 January 2024. A referral was subsequently made to the NMC, which was received on 27 February 2024.

The NMC's position is that your conduct amounts to misconduct and that your fitness to practise is currently impaired.

Decision and reasons on the application to find no evidence in Charge 2

The panel heard an application made by Ms West-Hunter to offer no evidence in relation to charge 2. The application was made pursuant to Rule 24(7) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004. Charge 2 alleged that your conduct resulted in bruising to Patient A.

Ms West-Hunter submitted that the evidence could not establish on the balance of probabilities whether the bruising observed was caused by the first sternum rub, which was accepted as clinically justified or the second sternum rub, which is disputed and forms part of charge 1(a)(i).

Ms West-Hunter submitted that, in the absence of reliable evidence linking the bruising to any specific act, it would be inappropriate to pursue this charge further. She concluded her submissions by stating that the NMC does not intend to proceed further with Charge 2.

The panel accepted the advice of the legal assessor.

The panel determined that it was appropriate to grant the application. It was satisfied that, in the circumstances, it would not be fair or proportionate to pursue Charge 2. The panel therefore determined that no evidence would be offered in relation to this charge, and there will be no findings made by the panel in relation to this charge when it considers its decision on facts

Decision and reasons on the application to hear witness health issues in private

The panel heard an application made by Ms West-Hunter, to hold part of the hearing in private to discuss a health matter relating to a Witness 2. The application was made pursuant to Rule 19 of the ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

[PRIVATE]. She submitted that the discussion regarding Witness 2’s medical status and ability to give evidence should take place in private to respect her confidentiality.

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

The panel determined that it was appropriate to accede to the application. It was satisfied that the discussion involved confidential personal health information and should be conducted in private to protect Witness 2's privacy.

Decision and reasons on the application to show the CCTV footage in private

The panel heard an application made by Ms West-Hunter to play the CCTV footage of the incident in private session.

Ms West-Hunter submitted that the CCTV involved scenes of significant distress featuring a young person. She further submitted that the footage included sensitive material which, if shown publicly, could undermine the dignity and privacy of the patient involved.

The panel accepted the advice of the Legal Assessor.

The panel determined that it was appropriate to accede to the application. It noted the need to protect the privacy and dignity of Patient A, who was a young and vulnerable person. The panel therefore directed that the CCTV footage be viewed in private session.

Decision and reasons on the application for a witness order in respect of Witness 3

The panel heard an application made by Ms West-Hunter inviting the panel to consider issuing a witness order of its own motion under Rule 22(5) in respect of Witness 3.

You had informed the panel that Witness 3 had witnessed part of the incident and could provide contextual evidence regarding the events of 20 September 2023, the ward environment, staffing concerns, and de-escalation techniques.

Ms West-Hunter submitted that she is taking a neutral position, noting that although Witness 3 may not have witnessed the entire incident, she may still be able to assist the panel.

The panel accepted the advice of the Legal Assessor.

The panel determined that it was fair and appropriate to accede to the application and issue a witness order requiring Witness 3 to attend the hearing. The panel considered that Witness 3 may be able to provide relevant factual and contextual evidence which would assist in ensuring that you receive a fair hearing.

Decision and Reasons on Application to Admit Hearsay Evidence Relating to NMC Witnesses

The panel heard an application made by Ms West-Hunter under Rule 31 to allow a number of hearsay documents into evidence. These were:

- An expert report from the CCTV reviewer, Witness 4; and
- A written statement from Patient A.

In addition, the following staff statements were also included:

- A written statement from Witness 5;
- A written statement from Witness 6; and
- A handwritten statement from Witness 7.

These statements were all included as part of the internal investigation conducted by the Hospital following the incident and were exhibited by Witness 2.

Ms West-Hunter submitted that although the individuals providing these statements would not be attending to give live evidence, the documents were clearly relevant and should be admitted. She further submitted that, although the evidence may carry less weight in the absence of cross-examination, the statements provided important context and helped corroborate live evidence already given, particularly as to your demeanour and conduct during the incident.

Ms West-Hunter submitted that the documents were made close in time to the incident and within a formal internal investigation process, which supported their reliability. She further submitted that their corroborative value across multiple sources increased the credibility of the evidence. Ms West-Hunter stated that the evidence was not the sole or decisive basis for the charges and would be considered alongside other forms of evidence, such as CCTV and oral testimony.

You had no objection to the application. You stated that you had no opposition to the documents being seen by the panel and were content for the panel to proceed on that basis.

The panel accepted the advice of the Legal Assessor.

The panel gave the application serious consideration. It noted that the statements formed part of a formal internal investigation and, while not all were prepared for the purpose of these proceedings, they were made in a structured and timely context. The panel accepted that the NMC had not sought to call the witnesses to give live evidence but also noted that the statements were not the sole or decisive basis for the case. The panel considered that many of the matters raised in the statements had already been the subject of oral evidence and had been addressed in cross-examination or could be tested further when you give your evidence.

The panel took into account that the evidence was not unchallenged, particularly in relation to observations about your demeanour and decisions during the incident, and that you would have the opportunity to address and respond to those matters. The panel was mindful of the seriousness of the charges and the potential impact on your career, but was satisfied that admitting the statements would not prejudice your ability to respond fairly.

The panel also noted that it found the documents helpful and relevant to its understanding of the incident and its context. It therefore determined that the hearsay statements were admissible and confirmed that it would assess the

appropriate weight to be given to each document in light of all the evidence before it, including your oral evidence.

Decision and reasons on application to adjourn hearing to Tuesday 22 April 2025

Ms West-Hunter made an application under Rule 32 for a short adjournment of the hearing until Tuesday 22 April 2025. She explained that the NMC had intended to call Witness 2 to give evidence that morning. However, due to a clerical error, the incorrect telephone number had been used when initially attempting to contact Witness 2. This was only discovered at approximately 11:15 am. Subsequent attempts to reach her via the correct number, including calls and messages, had been unsuccessful.

[PRIVATE]. Ms West-Hunter submitted that, although the public interest in efficient disposal of cases is important, there was also a strong public interest in ensuring that the panel had access to all relevant evidence in order to reach a properly informed decision.

She further submitted that Witness 2's evidence was central to the case. In particular, she had produced a chronology of the CCTV footage, provided important context for several staff statements, and was expected to speak to issues including the Hospital's training on the use of force and proportionality. Ms West-Hunter stated that you had indicated a wish to ask questions of Witness 2, and that a short adjournment would allow for that opportunity. She also raised the possibility of the panel issuing a witness summons under Rule 22(5), should further difficulty arise with securing the witness's attendance.

You did not oppose the application for an adjournment. You further expressed your disappointment with the delay, particularly given the impact on your personal and professional life, noting that you are currently off work and had anticipated that the hearing would be concluded within the originally scheduled timeframe.

You informed the panel that this was not the first delay in the proceedings and conveyed your growing frustration that the process appears to be repeatedly

prolonged. You further stated that you wished to hear from Witness 2 and had prepared a number of questions in anticipation of her evidence. You stated that you understood the importance of her testimony and, given the circumstances, agreed that an adjournment was necessary.

The panel accepted the advice of the legal assessor.

The panel carefully considered the application and decided that it was appropriate to adjourn the hearing until Tuesday 22 April 2025 in order to hear from Witness 2. The panel accepted that Witness 2 was a key witness in the case and that her evidence was of central importance, both to the NMC and to you. The panel noted that she had exhibited a significant volume of documentation, including hearsay material already admitted into evidence, and was in a position to assist with interpretation of the CCTV footage, as well as to speak to issues concerning the Hospital's internal policies and staff training.

The panel also noted that you had indicated a clear desire to cross-examine Witness 2 and had prepared questions for her. The panel considered that fairness to both parties required that you be given the opportunity to do so. While the panel was mindful of the public interest in the efficient progression of fitness to practise proceedings, it was equally mindful that fairness to all parties and the completeness of the evidence before the panel were of overriding importance.

The panel took into account that there was some medical evidence to support the witness's unavailability. [PRIVATE].

In view of this, the panel directed that the hearing be adjourned until Tuesday 22 April 2025. The panel also directed that a witness summons be issued to Witness 2 to support her attendance on that date. The panel expressed the view that this would assist in ensuring her presence and provide clarity about the expectation that she attend, subject to [PRIVATE].

Decision and Reasons on Application to Admit Hearsay Evidence Relating to Your Witnesses

The panel heard an application made by Ms West-Hunter under Rule 31 to admit into evidence two witness statements from Witness 8 and Witness 9, who were due to give evidence on your behalf, as hearsay. She informed the panel that the statements had been obtained during the course of an internal investigation conducted by the hospital and had originally been submitted as part of that process. The statements were made by individuals who are members of the hospital staff and are being relied upon on your behalf.

You made no formal objection to the admission of the statements.

The panel accepted the advice of the legal assessor.

The panel determined that the two witness statements from Witness 8 and Witness 9 should be admitted into evidence as hearsay and would consider them in the context of all the evidence before it, attaching such weight to them as it deemed appropriate.

Decision and Reasons on Application to admit further video evidence

The panel heard an application made by you to admit further video footage into evidence. The application was made pursuant to Rule 31 which governs applications concerning the admission of further evidence, including additional video footage during a hearing.

You informed the panel that the footage, which had only recently become available, captures the incident in which you were attacked by Patient A. You submitted that the footage shows both the nature of the assault and the length of time for which you were subjected to it. You informed the panel that this evidence may assist in contextualising your emotional and physical presentation in the immediate aftermath of the incident, and in the moments leading up to the events under consideration.

You further informed the panel that the footage had been produced by Witness 4, and that accompanying statements had been made by members of hospital staff. You confirmed that the video evidence was being put forward subject to the panel's decision on admissibility.

Ms West-Hunter made no formal objection to the application.

The panel accepted the advice of the Legal Assessor.

Having considered the submissions, the panel was satisfied that the footage was relevant and potentially probative. The panel determined that its admission would not prejudice the fairness of the proceedings and that it would assist in assessing the evidence in the round.

Accordingly, the panel granted the application and directed that the further video footage be admitted into evidence.

Decision and reasons on facts

Before turning to its findings on the facts, the panel first considered the background and overall context of the case. The panel heard that you were employed as a registered nurse and that, on 20 September 2023, the date of the incident, you were working as the nurse in charge in your role as Clinical Team Lead, alongside only one other nurse.

The panel noted that the incident took place on a high-risk ward providing care to young people aged 12 to 18 years. The panel heard evidence from you and from Witness 3, that the ward was an exceptionally volatile and challenging environment. It was specifically designed to assess and manage the risk profiles of its patients, many of whom were permitted to engage in risk-taking behaviour as part of their therapeutic care planning.

While violent incidents were reported to occur regularly, the panel heard that the use of pain compliance techniques was extremely rare and considered an option of last resort. The panel took into account evidence that several staff members had never used such techniques in their careers, including you, for whom this was the first occasion. It was further emphasised that pain compliance was only used in the most extreme circumstances, given its potentially significant impact on both patients and staff.

The panel acknowledged that the events involving Patient A unfolded under heightened and stressful conditions, particularly as you had been subjected to a physical assault earlier the same day. These contextual factors were taken into account by the panel when assessing the evidence and making findings in relation to each of the charges.

In reaching its decisions on the disputed facts, the panel considered all the oral and documentary evidence presented in the case, along with the submissions made by Ms West-Hunter and by you.

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: Specialist Nurse at the Hospital; and
- Witness 2: Hospital Director at the Hospital.

The panel also took account of the witness statements from the following witnesses on behalf of the NMC, which was admitted as hearsay evidence:

- Witness 4: Staff at the Hospital;
- Witness 5: Staff at the Hospital;
- Witness 6: Staff at the Hospital; and
- Witness 7: Staff at the Hospital.

The panel also heard evidence from you under oath, as well heard live evidence from the following witness on your behalf:

- Witness 3: Staff at the Hospital

The panel also took account of the witness statements from the following witnesses on your behalf, which was admitted as hearsay evidence:

- Witness 8: Support Worker at the Hospital

- Witness 9: Support Worker at the Hospital

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 you and the NMC.

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

Charge 1(a)(i):

That you, on 20 September 2023, used force against Patient A in that you used a second sternum rub (rubbed your fist against Patient A's chest) when not clinically justified.

This charge is found proved.

The panel took into account CCTV footage which showed your fist making direct contact with the centre of Patient A's chest. The panel noted that the motion was deliberate and caused Patient A to move backwards, suggesting a purposeful application of force. You denied using a sternum rub and stated that your arm was raised defensively to protect yourself from hair pulling.

The panel also considered your explanation in detail but did not find it credible in light of the video evidence. The footage clearly showed that the contact was not incidental, but forceful and intentional. The panel also took into account that you had previously been violently assaulted by Patient A, which may have influenced your perception of the situation. However, the panel determined that this action was not clinically justified at the time, nor was it consistent with accepted pain compliance techniques. The panel concluded that you used a second sternum rub, and that it was inappropriate in the circumstances.

Charge 1(a)(ii):

That you held Patient A's neck/lower jaw (mandibular movement) when not clinically justified.

This charge is found proved.

The panel considered extensive CCTV footage and noted that, on multiple occasions, your hands were placed around Patient A's neck and lower jaw area, rather than on the crown or forehead as is expected in approved restraint techniques. You asserted that your grip was loose and did not restrict the patient's breathing.

The panel took into account the evidence of Witness 1, who explained that even in volatile situations, it is possible to reposition and apply appropriate holds once the situation stabilises.

The panel also noted that your technique differed markedly from that of your colleagues, who consistently maintained proper hand placement. While there was no evidence that Patient A suffered harm as a result of the positioning, the panel determined that your repeated use of an incorrect hold created a risk of airway restriction and was not clinically justified. The panel concluded that the allegation is proved.

Charge 1(a)(iii):

That you placed your forearm/hands around Patient A's throat.

This charge is found proved.

The panel took into account footage which showed your arms and hands encircling Patient A's throat on several occasions during restraint. Although you stated that the holds were loose and that Patient A was able to speak, the panel noted that the positioning was not consistent with safe restraint techniques.

The panel considered that, even if there was no evidence of direct harm, the nature of the hold created a potential risk to the patient's breathing. The panel also noted that other staff members were able to use correct positioning and still maintain effective control of the patient.

The panel determined that your approach was not only contrary to training but was repeated throughout the footage, reinforcing that this was not an isolated lapse. This charge is found proved.

Charge 1(a)(iv):

That you moved Patient A's head to the right while in floor holds on more than one occasion.

This charge is found proved.

The panel considered CCTV footage and your own admissions in relation to this charge. You accepted that you moved Patient A's head during floor restraint in response to concerns about biting and safety. However, the panel took into account the oral evidence of Witness 1, who explained that repositioning of the head in such a way should only be done gently and when absolutely necessary.

The panel noted that the movement of the head appeared abrupt and forceful, rather than measured or controlled. The panel considered that, although you acted in a heightened and reactive environment, the force used was greater than necessary and could have been avoided. The panel determined that the movement was not clinically justified and was executed in a manner inconsistent with safe restraint techniques. This charge is found proved.

Charge 1(b)(i):

That you shouted at or argued with Patient A.

This charge is found proved.

The panel considered the evidence of Witness 2, who observed you raising your voice and engaging in what she described as a heated exchange with Patient A. The panel noted that while the CCTV had no audio, your body language was consistent with someone shouting or arguing. You accepted being distressed and agitated at the time but denied deliberately shouting.

The panel took into account that the incident occurred shortly after a physical assault and that your emotional state may have contributed to your behaviour. However, the panel determined that the combination of visual evidence and credible testimony from Witness 2 established, on the balance of probabilities, that you did shout at or argue with Patient A.

Charge 1(b)(ii):

That you entered Patient A's personal space causing them to step back.

This charge is found proved.

The panel took into account CCTV footage which showed you approaching Patient A at close range, prompting them to step backwards on three separate occasions. You

stated that your intention was to maintain confidentiality during the conversation, but the panel noted that your proximity led to the patient being physically cornered.

The panel considered the submission by Ms West-Hunter, who pointed out alternative options you could have taken to preserve privacy without invading personal space. The panel determined that your actions, whether intentional or not, caused Patient A to retreat and contributed to their agitation. This charge is found proved.

Charge 1(b)(iii):

That you said that you were going to lose your “fucking shit” or words to that effect.

This charge is NOT found proved.

The panel considered the evidence of Witness 2, who claimed to have heard you use the words in question. You denied using those specific words, though you acknowledged swearing in frustration during a highly stressful moment. The panel noted that no other witnesses corroborated the statement and that the alleged comment was whispered and may not have been heard by others.

Given the lack of supporting evidence and the conflicting accounts, the panel determined that it could not be satisfied, on the balance of probabilities, that the precise words alleged were used or that they aggravated the patient. This charge is not found proved.

Charge 1(b)(iv):

That you returned to the seclusion room on more than one occasion when told not to.

This charge is found proved.

The panel considered consistent evidence from multiple witnesses, including Witnesses 1, 2 and 3, who stated that you were advised to stay out of the seclusion room following the incident due to concerns that your presence was exacerbating Patient A's distress. The panel also took into account CCTV footage which showed you re-entering the room more than once despite these warnings.

You accepted in your own evidence that, with hindsight, you should not have returned to the room. The panel acknowledged that you were acting under pressure and may have felt a sense of responsibility for your colleagues. However, the panel determined that your actions disregarded advice given for the benefit of the patient and that your presence further aggravated the situation. This charge is found proved.

Fitness to practise

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

Mr Perriam, on behalf of NMC, invited the panel to take the view that the facts found proved amount to misconduct.

The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015'(the Code) in making its decision.

Mr Perriam identified the relevant standards where he believed your actions amounted to misconduct. He submitted that the relevant parts of the Code have been breached and are so serious they amount to misconduct. He invited the panel to have regard to the case of *Roylance v General Medical Council* (No. 2) [200] 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.'*
Mr Perriam next invited the panel to have regard to the case of *General Medical Council v Meadow* [2007] QB 462 (Admin).

Mr Perriam submitted that the behaviour in the facts found proved are so serious, that they fall short of the standards of the Code and satisfies the test for misconduct.

He submitted that in the course of your clinical practice there was unjustifiable and aggravated use of force that created a risk of harm to a patient.

He submitted that charges 1(a)(i), 1(a)(ii), 1(a)(iii), 1(a)(iv), 1(b)(i), 1(b)(ii), and 1(b)(iv) found proved, reveal serious breaches of the fundamental standards expected of a professional regulated nurse and amount to misconduct.

Mr Perriam referred the panel to the NMC Guidance FTP 12 and submitted that the panel has regard to the context in which the behaviour took place, that is of a patient attacking and injuring you shortly before the incident.

Mr Perriam accepted that you did not leave the incident as you were concerned that there was not another senior member of staff to take over from you. He further submitted that the context of the incident was one where you were in a very challenging situation and in difficult circumstances, all of which must be recognised. He submitted that these contextual factors do not excuse your behaviour and the breaches of the standards set out in the Code.

Mr Perriam submitted that your behaviour risked causing serious harm to the patient and that the use of two breakaway techniques should only be used in an emergency response when someone is at risk of a life-threatening injury. Furthermore, you were aggressive during the incident shouting and arguing with the patient.

You submitted that you accept that your behaviour amounted to misconduct.

You submitted that your actions during the incident were not your normal character and that you felt scared and disoriented and that you have been involved in a number of similar situations and there had not been cause for concerns about your practice.

You submitted that during the incident, you did not recognise that you could have involved other senior colleagues in dealing with the patient.

You accepted that you should have left the situation you found yourself in with the patient as you accept you were not in the right state of mind to be caring for the patient due to your injury, although you had a good previous rapport with the patient.

Submission on impairment

Mr Perriam moved on to the issue of impairment and submitted that your fitness to practise is currently impaired by reason of your misconduct.

Mr Perriam referred to the NMC Guidance, and in particular to DMA-1 in his submissions on impairment. He submitted that it highlights a particular question when deciding whether a person's fitness to practise is impaired or not. That is, can a nurse practice kindly, safely and professionally. Mr Perriam submitted that the answer to this question is no.

In considering the nature of a regulatory concern and the public interest, the panel should consider whether a registrant has in the past acted and/or is liable in the

future to act in a way, that may put a person receiving care at unwarranted risk of harm.

Mr Perriam submitted that there was a risk of physical and psychological harm to the patient and that this risk remains for other patients, as this concern has not been adequately addressed by you. He submitted that the nature of the concern also involves the panel considering whether you have in the past or are likely in the future to breach the fundamental tenets of the profession.

Mr Perriam submitted there is little evidence of insight, reflection, learning or training that demonstrate how you have strengthened your practice in areas such as restraint, de-escalation and managing challenging patients.

Mr Perriam submitted there are attitudinal issues about your behaviour towards the patient and the level of force you considered appropriate in that particular situation.

Mr Perriam invited the panel to consider the conduct that led to the outcome and to consider whether the conduct could be addressed by completing training courses, or supervised practice. He submitted that attitudinal concerns are more difficult to address.

Mr Perriam submitted that a nurse who can demonstrate insight and reflect on an incident objectively should be able to recognise what went wrong. He referred the panel to the submissions you have made that include various reflection pieces, including the reflective piece dated 26 January 2025. He invited to the panel to consider whether the reflections submitted demonstrate sufficient insight. He further submitted that they do not.

Mr Perriam submitted that you have failed to understand why the techniques you used on the patient were wrong. That you have failed to adequately provide an answer on what techniques you would use in the future.

There is little information before the panel that shows that you understand what went wrong, and what you would do if placed in a similar situation in the future. Mr

Perriam submitted that you have however shown regret and remorse but little insight on how these concerns would be addressed in the future. He submitted that you did not recognise the nature of the incident from an objective point of view or how your actions fell short of the standards to be expected.

Mr Perriam submitted that the references received from three former colleagues are of limited value as they relate to a period of time before the incident, and do not address the current regulatory concerns or comment on your current practice since the incident.

The most recent reference relating to your current employment at [PRIVATE]e Care Home is from your current mentor and although positive in nature it does not refer to the regulatory concerns being considered by this panel.

Mr Perriam submitted that due to the lack of evidence, insight and remediation the risk of you repeating this conduct found proved remains and you are still a risk to the health, safety and wellbeing of the public.

Mr Perriam submitted that a finding of impairment necessary to uphold standards of conduct and maintain public confidence in the profession.

You submitted that you accept that your behaviour amounted to misconduct and that your fitness to practise was impaired at the time of the incident in September 2023.

You submitted that since the incident you have reflected on your actions and taken steps to improve your practice. You accept that you should have removed yourself from the incident area after you had been injured by the patient and that is what you would do in future. You would accept advice from colleagues in such situations and recognise you are part of a team and that your behaviour will affect colleagues as well as patients. You stated that you had not behaved in any unacceptable manner in your six years of practice before this incident, although there had been many challenging situations at the specialist young person’s mental health unit.

You submitted that you have completed research on how to improve communication with patients, understanding body language, alongside de-escalation techniques.

You submitted that you are currently working in a role where you provide care for patients with dementia, Parkinson disease and end of life care. There has been no repetition although de-escalation is necessary currently with dementia patients. The care home wish you to work for them, although you have taken a break to concentrate on these regulatory hearings, [PRIVATE]. You stated that you have complied with your interim conditions of practice order.

In reflecting on the incident you have informed the panel that you have learnt a lot, you have regret about the way you behaved and are very sorry for the impact this had on the patient and your colleagues, you have changed your style of nursing, you listen more, seek support from colleagues and have regular supervision. You now recognise when you need help and quickly seek advice recognising that you do not have to deal with it all yourself. You believe the incident has made you a better nurse as you now have a greater understanding on how one decision can impact not only yourself but patients and other work colleagues.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor.

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

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, you failed to:

'1Treat people as individuals and uphold their dignity

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

‘8 Work co-operatively

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

8.2 maintain effective communication with colleagues

8.4 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

‘13 Recognise and work within the limits of your competence

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

‘20 Uphold the reputation of your profession at all times

20.1 keep to and uphold that 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

20.6 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.

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

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

The panel accepted that the circumstances you were in, were extremely challenging but your behaviour during the incident fell short of what is reasonably expected and that two of your restraining techniques were not clinically justified. You should have recognised that you should have removed yourself from the situation, something you yourself have now accepted.

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

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, 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 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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel determined that limbs a, b, and c are engaged.

The panel finds that a patient was put at risk of physical and emotional harm as a result of your misconduct.

Your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

In considering insight, the panel accept that you have shown developing insight and remorse into your actions. You have acknowledged that you should have done things differently during the time of the incident and worked collaboratively with other colleagues especially to allow you to leave the scene promptly when you had been injured by a patient. The panel does note that you have shown remorse, and you now recognise how your actions impacted the patient and your colleagues who were on duty during the incident.

The panel also noted that there have been steps taken by you to strengthen your practice but these steps remain limited.

The panel has taken into account the positive references which relate to your practice before the incident and the reference from your current mentor which does not raise any concerns about your practice which is also positive.

You have informed the panel that you are subject to an interim conditions of practice order and you have produced a copy of the last review in July 2025 from which it is apparent that you are complying with this order. You also informed the panel that your current employer is happy for you to continue to work there.

In considering whether there remains a risk of repetition, they panel does not have sufficient evidence of strengthening of your practice through additional training and full insight before it that it can be persuaded that you might not repeat your actions if

you were to be found in a similar situation again. Therefore, real risk of harm to patients still remains.

The panel determined that public confidence in the profession would be undermined if a finding of impairment was not made in this case and therefore the panel finds your fitness to practise impaired on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 18 months with a review. The effect of this order is that your name on the NMC register will that you are subject to a conditions of practice order and anyone who enquires about your registration will be informed of this order.

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

Submissions on sanction

Mr Perriam informed the panel that the NMC would seek the imposition of a striking-off order.

Mr Perriam referred the panel to the NMC Guidance submitted that the aggravating features in this case are:

- The conduct in question was an abuse of power
- The conduct placed a vulnerable patient at risk of serious harm
- There is insufficient evidence of insight or a strengthening practice through additional training
- The clinical failings demonstrate underlying attitudinal issues

Mr Perriam submitted that the mitigating features of the case were:

- This was a one-off incident, with no evidence of repetition since September 2023
- The incident took place in a heightened situation where you had been attacked beforehand.

Mr Perriam referred the panel to SAN-3 *'Available sanction orders'*

Mr Perriam submitted that taking no further action or imposing a caution order would be inappropriate given the seriousness of this case. It would also, not be proportionate in the public interest.

Mr Perriam submitted that there are no realistic or workable conditions of practice that could be formulated given the concerns. Furthermore, a conditions of practice order would not be appropriate due to the seriousness of the concerns.

Mr Perriam next considered a suspension order which he submitted would be insufficient to mark the seriousness of the conduct which put a vulnerable patient at risk of serious harm. The incident raises concerns about professionalism and attitudinal issues and is conduct that is a significant departure from the standards to be expected of a nurse.

Mr Perriam submitted that the serious breaches of the fundamental tenets of the nursing profession are fundamentally incompatible with remaining on the register. If any lesser sanction was imposed it would risk undermining public confidence in the profession.

Mr Perriam moved on to refer the panel to SAN-*2 'Considering sanctions for serious cases' and* SAN-3e '*Available sanctions orders'.*

Mr Perriam submitted that the nature of this incident does suggest that there are attitudinal issues in relation to patient care, making the behaviour sufficiently serious to be met with striking-off.

You submitted that you had a positive and unblemished record prior to this incident and have been a nurse for six years and no regulatory concerns having been made against you. In your post in 2023, you had been required to use restraining techniques between six and seven times each day on patients without concerns being raised.

You submitted that you are currently subject to an interim conditions of practice order imposed in March 2024. In your role working at [PRIVATE] Care Home, you are not allowed to use restraint techniques on patients but you do have to de-escalate situations with patients with dementia. The current conditions of practice order mean you are already being monitored and you have continued to practise safely without further concerns being raised.

You have reflected on the incident and reiterated that this was a one-off incident and that you should have left the patient after you were injured.

You told the panel that it was not your intention to hurt or harm the patient. You have reflected and learnt a lot about the incident. You have expressed regret and apologised for the impact your actions had on both the patient and your colleagues. You have told the panel that you have become more self-aware and can manage your emotions more effectively. You consider you are a better nurse now.

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 accepted legal advice and 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.

- Your actions at the time were a serious departure of what would be expected of a registered nurse
- Your actions at the time placed a vulnerable patient at risk of serious harm

The panel also took into account the following mitigating circumstances:

- This was one-off incident that took place immediately after you were assaulted, sustaining a significant injury which required treatment at hospital the next day
- You have demonstrated developing insight and shown full remorse over your actions
- You have worked within the care sector for 18 years including ten years as a support worker and in an environment that is both challenging and complex
- At the time of the incident, you were working on a difficult ward with vulnerable and challenging young persons mental health patients
- Although there had been a risk of serious harm the patient did not suffer actual physical harm as a result of your wrongful actions, the charge alleging bruising suffered by the patient was withdrawn by the NMC at the outset of the case
- Since the incident you have changed the way you practised – you are careful to seek advice from your colleagues and utilise their skills and experience

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 neither appropriate or proportionate, nor in the public interest to take no further action.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, public protection and public interest 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 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 your registration would be sufficient and appropriate response which would protect the public and the reputation of the profession. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel did not consider that there is an underlying attitudinal issue in this case. The panel took into account that you have practised safely and professionally under an interim conditions of practice order made in March 2024, as confirmed by the positive testimonial from your mentor. The panel accepted that you would be willing to comply with conditions of practice.

The panel had regard to the fact that this was a one-off incident that took place immediately after you had been assaulted by the patient. Your injuries required medical attention in hospital the following day.

You have been a registered mental health nurse for at least six years, prior to becoming a registered nurse you had been working within the care sector as a support worker for over 10 years. You have demonstrated developing insight and awareness into your behaviour and told the panel that you have completed research in improving your communication skills with patients as well as learning more about de-escalation techniques that can be used with patients.

In your current role, you are working under an interim conditions of practice and there has been no evidence of repetition of the behaviour that resulted in the

regulatory concern made against you. You told the panel that your current employer is happy to continue your current employment and you intend to remain there for an appreciable period of time before considering any return to a specialist mental health unit.

The panel has determined that it is in the public interest that, with appropriate safeguards, you should be able to continue practising as a nurse.

The panel was satisfied that a fully informed member of the public that following a sustained attack and restraint imposed on you by the patient for over five minutes, your subsequent actions were out of character and now much regretted by you. You suffered a possible whiplash injury and clumps of your hair were pulled out and you had to attend hospital for those injuries. The panel noted that the patient also assaulted other colleagues which did influence your actions.

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

The panel's decision that given the one-off nature of the incident and your developing insight and remorse. To impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of your case.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will not alone protect the public but will also mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

In making this decision, the panel carefully considered the submissions of Mr Perriam in relation to the striking-off sanction that the NMC was seeking in this case. However, the panel considered that there are realistic and workable conditions of practice which can be formulated and which, and on the facts of this case the conditions of practice order is the proportionate sanction.

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

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

1. You may only have one substantive employer, this must not be an agency.

2. You must meet with your Clinical Supervisor on a monthly basis, to discuss your clinical practice and coping strategies.

3. You must work with your manager or clinical supervisor to create a personal development plan (PDP). Your PDP must address the concerns about your behaviour with regard to:

    a. restraint
    b. conflict management
    c. de-escalation, and
    d. advanced communication skills

    You must: send your case officer a copy of your PDP after six weeks of restarting work. You must send your case officer a report from your manager or clinical supervisor every three months. This report must show your progress towards achieving the aims set out in your PDP.

4. You must not be the nurse in charge, where restraint and/or seclusion is required, until such time that you have completed additional training and been signed off as safe to do so. However, you may be part of the team that is managing patient restraint.

5. If working in a specialist mental health unit, you will need to undertake additional training in the following areas;
    - restraint
    - conflict management
    - de-scalation, and
    - advanced communication skills

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

7. You must keep us informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

8. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any employers you apply to for work (at the time of application).
    c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

9. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.

b) Any investigation started against you.
c) Any disciplinary proceedings taken against you.

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for up to 18 months.

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

Any future panel reviewing this case would be assisted by

- Evidence of your monthly supervision meetings
- Copy of your personal development plan and progress
- A reflective piece on how your clinical practice has changed in relation to the regulatory concerns
- Testimonials from your current line manager covering the concerns that have been identified by this panel

This will be confirmed to you in writing

Interim order

As the conditions of practice order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied

that it is necessary for the protection of the public, is otherwise in the public interest or in your own interests until the conditions of practice sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Perriam.

He submitted that an interim conditions of practice order should be imposed to cover the 28-day appeal period. This order should be the same terms as the Substantive order. Furthermore, an interim conditions of practice order is appropriate and proportionate. It is necessary to protect the public and is in the public interest for the same reason the panel found in the Substantive order.

You did not object the interim order application.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

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

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

That concludes this determination.