

**Nursing and Midwifery Council
Fitness to Practise Committee**

**Substantive Meeting
Monday, 12 January 2026 – Thursday, 15 January 2026**

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

Name of Registrant: Mark Alan Fratson

NMC PIN: 97C1625E

Part(s) of the register: Registered Nurse - Sub Part 1
RNMH: Mental Health Nurse, Level 1 (20 March 2000)

Relevant Location: Hull

Type of case: Misconduct

Panel members: Graham Coulston-Herrmann (Chair, Lay member) Anita Mobberley (Lay member) Catherine McCarthy (Registrant member)

Legal Assessor: Paul Housego

Hearings Coordinator: Abigail Addai

Facts proved: Charges 1), 2), 3), 4), 5), 6), 7), 8), 9)

Facts not proved: N/A

Fitness to practise: Impaired

Sanction: Striking-Off Order

Interim order: Interim Suspension Order (18 Months)

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mr Fratson's registered email address by secure email on 4 November 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, dates and venue of the meeting.

In the light of all of the information available, the panel was satisfied that Mr Fratson has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended (the Rules).

Details of charge

That you, a registered mental health nurse on 27 April 2016:

1. Failed to properly review Patient A's records before meeting with them.
2. When asking for advice from Colleague 2 and/or Colleague 3 about Patient A, did not inform them about Colleague 1's email.
3. Failed to conduct a mental health assessment or re-assessment with Patient A.
4. Did not take Patient A into a private room.
5. Told Patient A that they need not have come to the appointment and/or that they already been assessed.
6. Did not adequately explain any next steps to Patient A.

7. Recorded in Patient A's medical records that secondary mental health services were unaware of the full assessment completed by psychiatric liaison when this was not correct.
8. Your actions at charge 7 were dishonest in that you deliberately sought to imply that Colleague 1 had not been aware that Patient A had already been assessed when you knew that he was aware.
9. Your actions at charges 1 to 8 above caused Patient A to lose a chance of survival.

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

Background

On 9 August 2018, the NMC received a referral from Humber NHS Foundation Trust about Mr Fratson's performance during a pre-booked assessment by the Secondary Mental Health Services at [PRIVATE] on 27 April 2016.

It is alleged that Mr Fratson was scheduled to re-assess Patient A, who had already been assessed in Accident and Emergency (A&E) on 23 April 2016. Mr Fratson had received an email from a Senior Colleague, Colleague 1, who was an experienced Band 7 nurse, detailing that he wanted Mr Fratson to conduct a re-assessment of Patient A. He was allocated time to do so, and a room was booked for this to be carried out. Colleague 1 also recorded his concerns on the electronic recording system, Lorenzo. On 27 April 2016, Patient A and her partner presented at [PRIVATE] for the scheduled appointment. It is alleged that Mr Fratson sought advice from Band 6 nurses, Colleague 3, Witness 1 and Colleague 2 about the necessity of completing a re-assessment on Patient A. It is alleged that Mr Fratson did not disclose to them the email that Colleague 1 had sent to Mr Fratson or give them a full account, and simply asked if a full re-assessment was required when one was undertaken two days previously. They advised that Mr Fratson did not need to complete a full assessment again. Mr Fratson then met with Patient A and her partner in a

corridor and told them that there had been a mistake, stating that she had already been assessed and they did not need to come in today. Patient A left [PRIVATE].

Witness 3, the partner of Patient A, describes this as another massive blow for her and she stated, in the car afterwards, that nobody could help her. Patient A was subsequently found hanged in her home on 29 April 2016.

An Inquest was held and it was found that there was a total of eight contacts with the Trust prior to Patient A's death. Mr Fratson was the penultimate contact.

The NMC instructed an expert to provide an opinion for this case. The Professor was provided with the witness statements and exhibits in the case in addition to the reports compiled by Witness 4 and Witness 2. An NMC statement and the report from Witness 2 has been included in the exhibits bundle before the panel as it touches, not only on the events of 27 April 2016, but also the wider context of Patient A's care and treatment. This has been referred to by the Professor as providing him with some of the information that he requires to assist the panel in respect of the question of Mr Fratson's conduct, as a cause or contribution to the death of Patient A.

Mr Fratson accepted that he had seen Patient A in the corridor and regretted that he had not taken her to a private room, but did not accept that he had done anything wrong. He said that the other nurses lied in their accounts.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Band 6 Clinical Lead in the [PRIVATE] at the time of the concerns;
- Witness 2: Mental Health Nursing Expert Witness at the time of the concerns;
- Witness 3: Patient A's Partner at the time of the concerns;
- Witness 4: Head of Transformation at The Trust at the time of the concerns;
- Colleague 1: Band 7 Nurse at The Trust at the time of the concerns;
- Colleague 2: Mental Health Nurse at the Trust at the time of the concerns;
- Colleague 3: Band 6 Nurse at the Trust at the time of the concerns.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The burden of proving the allegations is on the NMC. The standard of proof is on the balance of probabilities. It considered the documentary evidence provided by the NMC.

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

Charge 1)

That you, a registered mental health nurse on 27 April 2016:

“Failed to properly review Patient A’s records before meeting with them.”

This charge is found proved.

In reaching this decision, the panel considered whether Mr Fratson had a duty to properly review Patient A’s records before meeting her.

The panel first had regard to the email dated 25 April 2016, sent by Colleague 1 which shows that Mr Fratson was copied in. Colleague 1 was an experienced and knowledgeable Band 7 Nurse and was senior to Mr Fratson. Colleague 1 cancelled a shadowing session that Mr Fratson was diarised to be carrying out that day and requested for Mr Fratson to undertake an assessment of Patient A, considering this more important and urgent. During interviews with Witness 4, Mr Fratson accepted that he had received this email. There were varying accounts of how much Mr Fratson had read and how he interpreted it.

Later he accepted that he had opened that email. He indicated that he did not think it was appropriate to make medically important entries by email and that as he was not the addressee, but copied in, it was for his information rather than directed at him.

It was questioned during the subsequent investigations whether Mr Fratson had the required experience to undertake the assessment. The panel noted that at various points during the interviews and statements, Mr Fratson pointed out that he had 17 years of experience and had recently conducted 70 assessments.

Mr Fratson stated:

‘I had probably seen about 70 patients in a very short amount of time, we were seeing between 2 and 3 patients a day’

The panel also considered whether Mr Fratson had sufficient time to carry out the review. Witnesses said he had ample time that day to carry out the review as he had an assessment that was cancelled in the morning, leaving him free. The panel had sight of Mr Fratson's diary for 27 April 2016, namely the section entitled 'jobs'. This clearly showed he had all morning to prepare for the assessment of Patient A.

The panel next had regard to the witness statement of Colleague 2 which further supports this:

'On that day, Mark failed to properly look at the patient's records, despite having ample time as he had all morning to review them... What Mark should have done instead was start by checking the patient's records. That is the first thing you do before you assess a patient. You look at the previous entries and find out why she had turned up at A&E. He should have read the referral form and the email from Colleague 1. All the information was there.'

The panel also noted Witness 4's findings which determined that Mr Fratson's answers were 'far from definitive' and highlighted Mr Fratson's claimed 'inability to recall whether or not he had read the triage document'. The report also highlighted that Mr Fratson was free from 9:00 and was not due to see Patient A until 12:00.

The evidence was clear that while Mr Fratson had ad hoc tasks in place, there was ample time to sufficiently prepare for Patient A's review. It had regard to Witness 1's witness statement which corroborates Colleague 2's witness statement. Witness 1 stated that Mr Fratson was not busy and could have sufficiently prepared.

The panel also considered that Mr Fratson made admissions to the facts alleged during his interview with Witness 4. Mr Fratson said that he saw the email requesting him to conduct the assessment. However, the panel found that Mr Fratson's comments in his interview contradicted his email dated 3 May 2016, which was sent after Patient A's death. Within the email, Mr Fratson says the following:

' I believe I checked my Lorenzo diary... I then printed off a triage referral and full mental health assessment for the client'

The panel noted from Colleague 2's witness statement that she had printed off the full assessment and gave it to Mr Fratson. The panel preferred the evidence of Colleague 2 and saw nothing to undermine her evidence when compared to the changing accounts given by Mr Fratson, and the evasive answers repeatedly given when he was interviewed.

The panel then referred back to Mr Fratson's interview with Witness 4. Witness 4 asked Mr Fratson if he looked on Lorenzo for Patient A's clinical record. Mr Fratson said:

'I did not know some of the stuff of Lorenzo either so I was only going on what I could do at the time, my interpretation of stuff.'

The panel was also satisfied that Mr Fratson was capable of using Lorenzo. Witness 2 states:

'In Mark's supervision documentation, you can see as part of his induction, he received quite detailed and intensive support in being shown how to access records, how to make one, transfer records. He was deemed competent. He had been using Lorenzo before he came with this team. He was familiar with the electronic record.'

As with Colleague 2, the panel preferred the evidence of the witnesses due to the inconsistencies of Mr Fratson's evidence and the evasiveness apparent from the interviews.

The panel determined that Mr Fratson had a duty to review Patient A's records before meeting with her. It noted that Colleague 1's instructions were clear that Mr Fratson was to conduct this assessment. He was regarded by all the clinical witnesses and his own admissions as competent to do so. The panel could find no clinical or other justification as to why Mr Fratson did not review Patient A's records prior to meeting with her. The panel finds that Mr Fratson did not do so properly, as charged.

Therefore, the panel found charge 1) proved.

Charge 2)

That you, a registered mental health nurse on 27 April 2016:

“When asking for advice from Colleague 2 and/or Colleague 3 about Patient A, did not inform them about Colleague 1’s email.”

This charge is found proved.

In reaching this decision, the panel understood the charge to refer to the content within the email.

The panel next took into account Colleague 2’s witness statement which reads:

‘He also didn’t tell us he had an email form [sic] Colleague 1... The problem with what Mark has done is that he didn’t tell us about the other information prior to going to see Patient A. He literally just said do I need to see someone who had been seen two days before.’

The panel found Colleague 2’s witness statement was corroborated by Colleague 3’s witness statement which reads:

‘Mark never told us about the email from Colleague 1. I only found out about Colleague 1’s email when Colleague 4 asked Colleague 2 and myself to come and speak with her about the incident.’

Colleague 3 also remained consistent on this point within her police statement where she says that Mr Fratson did not mention receiving an email from Colleague 1.

During Mr Fratson’s interview, Mr Fratson says that they discussed the email and discussed Colleague 1’s referral. However, the panel noted that Mr Fratson’s original statement to the Trust on 3 May 2016, makes no reference to the email. The panel found Mr Fratson’s evidence to be inconsistent with the witnesses’ evidence and found nothing to undermine the witness evidence of the two nurses. As a result, the panel preferred the evidence of Colleague 2 and Colleague 3.

In light of the above, the panel found charge 2) proved.

Charge 3)

That you, a registered mental health nurse on 27 April 2016:

“Failed to conduct a mental health assessment or re-assessment with Patient A.”

This charge is found proved.

The panel noted that a full assessment for Patient A had been carried out by a mental health nurse in A&E. However, Colleague 1 determined that this assessment was not up to standard and requested Mr Fratson to conduct a full re-assessment of Patient A. Colleague 1 also had cancelled Mr Fratson’s shadowing cover for this to be accommodated. This was confirmed by Mr Fratson within his diary entry for 27 April 2016 and his statements. The panel also found the email from Colleague 1 clearly set out that Mr Fratson was to conduct an assessment.

The panel also had regard to Colleague 1’s witness statement which reiterates that Patient A required another re-assessment and instructed Mr Fratson to conduct this assessment. Mr Fratson was considered ‘competent’. Mr Fratson’s competency in this area is further corroborated by Colleague 2’s witness statement which reads:

‘On 11 February 2016, I had a discussion with Mark about whether he was ready to undertake assessments on his own from week 3 which he said he was comfortable doing. We confirmed this with Colleague 5.

I checked Lorenzo and could see the assessment was on the system so I printed it off and gave it to Mark. I told Mark that he needed to go downstairs and reassess what was going on really. As far as I was aware he went to do that.’

The panel next considered whether Mr Fratson had a duty to assess Patient A. In doing so, it had regard to Witness 2’s witness statement which reads:

'Mark should have conducted a formal, full assessment as this was his job on the day.... Mark missed an opportunity to conduct a full reassessment on Patient A'

The panel also considered The Independent Medical Expert Report which reads:

'I note that in his statement to the NMC, Witness 2 mentions the interview conducted with Mark Fratson, when Mark Fratson could provide no reason why Patient A was not assessed, or why the Secondary Mental Health Operational Policy was not followed.'

The panel determined that this directly linked to the Trust Guidance on Delivery of the Care Programme Approach which reads:

'Central to the effective delivery of the care programme approach is comprehensive assessment review and subsequent reassessment of service users and carer needs.'

The panel also considered that the evidence before it linked to Colleague 3's witness statement which reads:

'To provide some context, what we would do at the time was when a patient first came to the service, we would undertake a full mental health assessment which covered everything. If the patient presented to the service again, we would then undertake a summary assessment that captured any changes since their last assessment. We wouldn't do a full mental health assessment again but you would need to assess whether there was any change since their last visit. That's the process that we followed'

Further, Witness 2 stated the following:

'In interview, Mark could not provide a reason for why Patient A was not reassessed or why the secondary mental health operational policy was not followed'

The panel determined that Mr Fratson was given clear instruction by Colleague 1 to reassess Patient A. It also found the Trust Guidance was clear that re-assessment is 'central' to the effective delivery of care. The witnesses also reiterated the importance of continual re-assessment. It was apparent to the panel that every time a patient attended the Service, it was a requirement that at minimum there must be a re-assessment or update as to concerns in order to make an enquiry as to the current situation. As a result, the panel could not find any clinical justification for Mr Fratson's failure to conduct a mental health assessment or re-assessment with Patient A.

Accordingly, the panel found charge 3) proved.

Charge 4)

That you, a registered mental health nurse on 27 April 2016:

"Did not take Patient A into a private room."

This charge is found proved.

The panel first considered that Mr Fratson said in his interview with Witness 4 that he wished that he had a private room from the start. He said that his colleagues told him to see Patient A downstairs, where there were no private rooms, and that he did not use the booked room as it was upstairs, and he was simply sending Patient A and her partner away, not re-assessing Patient A.

Later in interview with Witness 4, Mr Fratson said:

'I wish I could have just taken her to a room, that is one thing I would do differently'

Mr Fratson explained that he had taken Patient A from the entry lobby into a corridor '*for privacy*'.

The panel next took into account the email sent by Colleague 1 which stated that he had booked a room for Mr Fratson to conduct the assessment. The email was also clear that Mr Fratson's shadowing session had been cancelled to accommodate this assessment. This was also reflected in Mr Fratson's diary for 27 April 2016.

Witness 3, who was Patient A's partner, was present during Mr Fratson and Patient A's interaction and outlined the following in his witness statement:

'He told us this in a corridor. There were other patients coming down in the lifts. He was explaining this to us there. It was wholly inappropriate.'

In his interviews with Witness 4, Mr Fratson sought to explain his actions by saying that Colleagues 2 and 3 had told him to tell Patient A that they did not need anything further from her, and to inform her of this 'downstairs'. The panel did not believe this was credible and in any event, as an experienced practitioner, Mr Fratson should have known to meet with Patient A in the privacy of the booked room.

The panel was of the view that Mr Fratson had a duty to take Patient A to a private room. It noted that clear instructions were given to Mr Fratson by Colleague 1 who was senior to him. It saw nothing to undermine the evidence of Witness 3.

Therefore, the panel found charge 4) proved.

Charge 5)

That you, a registered mental health nurse on 27 April 2016:

"Told Patient A that they need not have come to the appointment and/or that they already been assessed."

This charge is found proved.

The panel noted that the word had is missing from the charge between they and already. Therefore, the panel took the charge as reading: "Told Patient A that they need not have come to the appointment and/or that they **had** already been assessed."

The panel took into account Witness 3's witness statement. Witness 3's witness statement reads:

'Mark said something along the lines of "she's already been assessed, we don't need to make that assessment twice." And I've got your paperwork, you shouldn't have come today'

The panel found that this was corroborated by the record Mr Fratson input in Lorenzo. The Lorenzo record stated that Patient A already had a full assessment. As such, Mr Fratson did not feel that there was a requirement to complete another assessment, and he accepted that is what he told Patient A and her partner.

The panel also had regard to the police statement of Mr Fratson which reads:

'I was again advised by Colleague 2 and Colleague 3 to meet with the client and apologise for the inconvenience of them attending that day and to tell them a full assessment and plan had been completed from their visit two days previously. I believe Patient A came in probably round about the allocated time; about half past one I think and I believe it was her partner who came with her although I did not get his name. I asked if they would come out of the waiting room and I took them into the hallway.

I took them into the hallway because there were no rooms available down there that you can just access just for use. The usual assessment rooms are in another part of the building but there are no rooms off reception when a patient can be spoken to in private. I invited them out of the waiting room to speak confidentially for what I believed to be a brief discussion and apology. I apologised for them attending that day and explained that the work had already been completed by the Psychiatric Liaison Team therefore we did not need to put Patient A through another full mental health assessment.'

Having regard to the above, the panel determined that it was more likely than not that Mr Fratson told Patient A they need not have come to the appointment and/or that she had already been assessed.

Therefore, the panel found charge 5) proved.

Charge 6)

That you, a registered mental health nurse on 27 April 2016:

“Did not adequately explain any next steps to Patient A.”

This charge is found proved.

The panel was directed to the witness statement of Witness 3. It also had regard to the witness statement of Colleague 1 and Mr Fratson’s police statement.

Witness 3’s witness statement reads:

‘I don’t even think Mark said they would be in touch. There was no plan of action. He had just handed her the assessment paper and that was it. I think out [sic] interaction with Mark lasted about three minutes.’

Colleague 1’s witness statement also reads:

‘He had spoken to them for about 5-10 minutes at the bottom of the stairs. Mark seemed to think his actions were entirely justified and appropriate’

The panel also took into account Mr Fratson’s police statement where he said he had spoken to Patient A and her partner for approximately 20 minutes. The panel found this evidence contrary to the accounts of Witness 3 and Colleague 1. Witness 3 was clear in his evidence that Mr Fratson had spoken to Patient A for a few minutes. The panel did not find it plausible that the conversation lasted 20 minutes because of the inconsistencies in the times raised by Mr Fratson, Colleague 1 and Witness 3. The panel accepted the

evidence of Witness 3. Mr Fratson accounted for the length of time by saying that he went and printed off documents to give to Patient A and her partner. Colleague 2 was clear that she had printed these off for Mr Fratson before he went down to see them.

Accordingly, the panel found charge 6) proved.

Charge 7)

That you, a registered mental health nurse on 27 April 2016:

“Recorded in Patient A’s medical records that secondary mental health services were unaware of the full assessment completed by psychiatric liaison when this was not correct.”

This charge is found proved.

In reaching this decision, the panel considered the following:

1. Whether the full assessment was in the records;
2. Whether Secondary Mental Health Services (Colleague 1) was aware of the full assessment;
3. Whether Mr Fratson had recorded in Patient A’s records that they were unaware of that record.

The panel noted that the full assessment had been carried out while Patient A was in the A&E department, by a mental health nurse. Mr Fratson was subsequently given this document and went to see Patient A. The panel also had sight of the email sent by Colleague 1, which informs Mr Fratson that Patient A was given an assessment by A&E. Colleague 1 informed Mr Fratson to conduct another assessment of Patient A and cancelled his shadowing session to accommodate this. The panel was of the view that the email was clear that a further assessment was required due to Colleague 1’s concerns around the adequacy of the original assessment. However, Mr Fratson did not reassess Patient A and subsequently wrote a record which is inaccurate. The Lorenzo record written by Mr Fratson states:

'SMHS Triage were unaware of this document on the system and it was felt there was no requirement to duplicate the work today'

In summary, Mr Fratson stated that the reason Colleague 1 had requested him to carry out a full assessment was because he (Colleague 1) was unaware of the A&E assessment.

The panel determined that there was sufficient evidence to show that Mr Fratson had deliberately recorded in Patient A's record that, secondary mental health services were unaware of the full assessment completed in A&E, when this was untrue.

The evidence was clear (and the panel finds) that Secondary Mental Health Services (Colleague 1) was aware of the A&E assessment. Colleague 1's email refers to it.

Therefore, the panel found charge 7) proved.

Charge 8)

"Your actions at charge 7 were dishonest in that you deliberately sought to imply that Colleague 1 had not been aware that Patient A had already been assessed when you knew that he was aware."

This charge is found proved.

In reaching this decision, the panel had regard to the NMC Guidance: *Making decisions on dishonesty charges and the professional duty of candour* (DMA-8) and *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67, paragraph 74:

'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to

facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards dishonest.'

The panel having read DMA-8 and *Ivey*, determined that Mr Fratson knew that Colleague 1 asked him to conduct a proper assessment of Patient A. The panel saw evidence that Colleague 1 had sent Mr Fratson an email setting out his concerns. Therefore, the panel was satisfied that Mr Fratson was given proper instructions. It took into account that Mr Fratson had sought advice from Colleague 2 and Colleague 3 but concluded that Mr Fratson only gave a partial account of what he was instructed to do. The panel concluded the reason for this was to convince the colleagues that he did not need to carry out an assessment of Patient A.

The panel was of the view that Mr Fratson deliberately tried to avoid undertaking any assessment of Patient A, despite clear instructions from Colleague 1. It noted that no form of re-assessment was attempted by Mr Fratson and he subsequently made an entry in Lorenzo which was untrue. Mr Fratson knew the entry he had made in Lorenzo was untrue, because he accepted that the email had been sent to him and that he had opened it. The panel did not find Mr Fratson's explanations for his assertion that he did not know that Colleague 1 knew of the A&E assessment convincing.

In making the assessment of whether Mr Fratson was dishonest, the panel also took into account Mr Fratson's interviews and the evasiveness of his answers, and noted that he deflected responsibility and sought to blame others. It was not credible that Mr Fratson, a nurse of 17 years' experience in mental health nursing, would take at face value a comment that an assessment was not required as an instruction. At the very least, Mr Fratson should have spoken to the patient for an update, checked on her current mental health and to see whether anything had changed. This for the panel indicated dishonesty.

The panel also noted that Mr Fratson had a history of avoiding work and had regard to Colleague 2's statement which reads:

'Mark was pretty good at avoiding work. He wouldn't do urgent tasks, wouldn't share his ledgers, he booked leave and didn't tell us or would be on courses and wouldn't tell us. It was hard to watch someone when I had my own job to do and we weren't in the same building. Mark always seemed to have an excuse for why he couldn't do something.'

The panel found this corroborated with Witness 1's interview within the Coroner's report which reads:

'Q. So you think on the one hand this was due to lack of knowledge or do you think it was due to work evasion?'

A. Work evasion. I don't believe there was a lack of knowledge. I believe that Mark had been supported adequately to ensure that he was fully aware of the assessment process and how that should have occurred.'

The panel decided that ordinary decent people would find Mr Fratson's actions:

- In sending Patient A and her partner away to avoid work he was instructed to do;
- by giving a partial account to colleagues and
- then relying on a literal construction of their response;
- failing to make any enquiry as to the mental health of Patient A; and
- then putting a false record in the Lorenzo system (charge 7) as to why he had not carried out the assessment he had been instructed to do; and
- then leaving work at 15:00 as he had not carried out the assessment scheduled to commence at noon; to be dishonest.

Accordingly, the panel found charge 8) proved.

Charge 9)

"Your actions at charges 1 to 8 above caused Patient A to lose a chance of survival."

This charge is found proved.

The panel had regard to the witness statement of Witness 3, The Independent Medical Expert Report and the NMC Guidance: *Investigating what caused the death or serious harm of a patient (causation)* (INV-4) and *Independent experts* (INV-5).

Witness 3's witness statement reads:

'I think that day at [PRIVATE], had Patient A been seen, I believe there would have been a different outcome. If she'd spoken to someone and someone had time to sit and listen to her in a professional way, I think there would have been a different outcome. I think the manner that we were treated at in [PRIVATE], the fact that we were spent waiting longer for the appointment and then only given three minutes in the corridor, that destroyed Patient A'

The panel found Witness 3's witness statement was corroborated by The Independent Medical Expert Report which reads:

'In my opinion, had Mark Fratson gathered further information at the arranged appointment with Patient A on 27th April 2016, he would have concluded that Patient A required further care and treatment. In this event, he could have sought advice from senior colleagues regarding a care and treatment plan. In my opinion, the presentation of Patient A required her to come under the care of a Crisis (intensive) home treatment team, or receive in-patient care. Both of these modalities of care and treatment would include elements of interventions by psychiatrists and mental health nurses, all set within the context of a multidisciplinary team.

For avoidance of any doubt, I agree with the conclusion of one of the Experts who assisted the Inquest (as cited in my letter of instruction) stated that, on balance, had Patient A been admitted to a psychiatric unit, or had intensive home treatment then it is likely that the deterioration of her mental state would have been better recognised and "she would likely have not committed suicide"

If the Committee accepts the evidence of [Witness 3] what then followed after they attended for the appointment with Mark Fratson, Patient A ‘...went spiralling downwards,’ In my opinion, Patient A’s sense of hopelessness must have therefore have been reinforced. There is a very longstanding consensus (supported by a very strong evidence base,...) that hopelessness is a major risk factor for suicidality.

For avoidance of any doubt, I am of the opinion that had Mark Fratson confirmed the substance of [Colleague 1]’s Triage assessment and obtained further detail from both Patient A and her partner, [Witness 3], he would have been in a position to put in place a plan that would have provided Patient A with interventions to treat her state of depression.

If the Committee accepts the evidence to the effect that Mark Fratson must have known that Patient A was in the condition described in [Colleague 1]’s email, as set out above, Mark Fratson must have been aware that simply sending Patient A away must (because of her suicidality) have put her safety at risk. In addition, I draw the Committee’s attention to the circumstances when Mark Fratson conducted his interaction with Patient A and [Witness 3]. He spoke to them in a public area, outside of a toilet, knowing that an interview room was but a short walk away and had been booked for a private interview. In my opinion, this matter alone must have had an enormous negative impact on Patient A’s sense of wellbeing.

With regard to whether Mark Fratson knew that it was unreasonable to take the risk, I can see no reason to say otherwise. I can only add that I am bewildered that Mark Fratson, a registered nurse, whose career had spanned so many years, knowingly took an unreasonable course of action when he, in effect, simply sent Patient A away. I am therefore of the opinion that Mark Fratson chose to take this risk.

In conclusion therefore, I am of the opinion that not only did Mark Fratson deliberately choose to take an unreasonable risk with the safety of Patient A when he saw on the 27th of April 2016, his actions on that day represented a material contribution to her death by suicide.’

The panel accepted the evidence of Witness 3.

The panel was of the view that Mr Fratson, a nurse with some 17 years of experience, should have taken steps to assist Patient A. The panel referred to Colleague 1's email which described Patient A as '*significantly depressed... self-neglect, suicidal thoughts*'. As such, had Mr Fratson heeded Colleague 1's instructions, he would not have put the safety of Patient A at risk.

While the panel noted that this was not the last interaction of Patient A with the NHS mental health services, the panel accepted the evidence of Patient A's partner, Witness 3, that being sent away by Mr Fratson left Patient A with a feeling of utter hopelessness, and a (mistaken) certainty that no-one could help her. The expert evidence before the panel is that this feeling of hopelessness is known to be a very significant driver of suicidal action.

In light of the above, the panel determined that it is more likely than not that Mr Fratson's actions at charges 1 to 8 caused Patient A to lose a chance of survival.

Accordingly, the panel found charge 9) 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 Fratson's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

circumstances, Mr Fratson's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

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

The 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.

The NMC submitted that Mr Fratson has fallen short of the standards set out in the Code, and what he did or failed to do, amounts to serious professional misconduct. They submitted that the actions reported and found proved are failings directly related to the care of a Mental Health patient and management of a vulnerable patient.

The NMC submitted that the actions proved against Mr Fratson are not simply breaches of a local disciplinary policy or minor concerns. Rather, they are matters fundamental to a professional's practice such as honesty and integrity. They submitted that the behaviour relates to Mr Fratson's role as a registered professional and it affected patient care in the worst possible way. Mr Fratson was asked by a Senior Colleague to see Patient A, and lacked compassion because he spoke to her in a corridor (despite a room being booked), and sent her away without doing any further assessment. The NMC submitted that his actions caused Patient A to lose a chance of survival. Additionally, Mr Fratson was dishonest by recording false information within Patient A's notes.

The NMC referred the panel to the NMC Guidance: *How to determine seriousness* at FTP-3, and FTP-3a/b relating to *concerns that are serious and more difficult to put right*.

The NMC considers the misconduct as serious breaches because Mr Fratson's actions and omissions fell seriously short of what is expected from a registered professional, and was conduct that fellow practitioners would find deplorable.

The NMC indicated that the panel should bear in mind its overarching objective to protect 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. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) and *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin).

The NMC submitted that the four limbs of the *Grant* test are satisfied. It can be said that Mr Fratson has in the past and is also liable in the future to put patients at unwarranted risk of harm. Mr Fratson's conduct brought the profession into disrepute and he has breached fundamental tenets of the nursing profession. The NMC also submitted that he acted dishonestly.

The NMC referred the panel to *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin) and asked it to consider the following questions:

- Whether the concern is easily remediable,
- Whether it has in fact been remedied and;
- Whether it is highly unlikely to be repeated.

The NMC submitted that the concerns relate to Mr Fratson's attitude and cannot be said to be easily remediable. The NMC consider Mr Fratson has displayed limited insight and has not returned the Case Management Form (CMF) so has not provided a formal response to the charges.

The NMC understand that Mr Fratson has not worked as a nurse since the issues and seems to have disengaged from the process. Mr Fratson has not undertaken any relevant training or undergone any reflection in respect of the issues of the concerns, therefore, the conduct has not been remedied and is likely to be repeated.

The NMC consider there is a continuing risk to the public due to Mr Fratson's lack of full insight, and failure to undertake relevant training or provide any reflection on the conduct.

With regards to public interest, the NMC consider a finding of impairment on this ground is required to declare and uphold proper standards of conduct and behaviour.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

'1 *Treat people as individuals and uphold their dignity*

To achieve this, you must:

1.1 *treat people with kindness, respect and compassion.*

1.2 *make sure you deliver the fundamentals of care effectively*

2 *Listen to people and respond to their preferences and concerns*

To achieve this, you must:

2.1 *work in partnership with people to make sure you deliver care effectively.*

2.6 *recognise when people are anxious or in distress and respond compassionately and politely.*

3 *Make sure that people's physical, social and psychological needs are assessed and responded to*

To achieve this, you must:

3.1 *pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*

3.3 *act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it*

5 *Respect people's right to privacy and confidentiality As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.*

To achieve this, you must:

5.1 *respect a person's right to privacy in all aspects of their care*

5.4 *share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality*

8 *Work co-operatively*

To achieve this, you must:

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

8.2 *maintain effective communication with colleagues*

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

8.6 *share information to identify and reduce risk*

10 *Keep clear and accurate records relevant to your practice. This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.*

To achieve this, you must:

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 *Recognise and work within the limits of your competence*

To achieve this, you must:

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

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

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

To achieve this, you must:

16.4 *acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so*

17 *Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection*

To achieve this, you must:

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

19 *Be aware of, and reduce as far as possible, any potential for harm associated with your practice*

To achieve this, you must:

19.1 *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place.*

19.2 *take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)*

20 *Uphold the reputation of your profession at all times*

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people.

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress'

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

The panel was of the view that Mr Fratson's actions was serious. It noted that Colleague 1 instructed Mr Fratson to re-assess Patient A and he was deemed competent to do so. The panel considered that Mr Fratson had a duty to undertake this instruction because Colleague 1 who was senior to him, gave him this instruction, and cancelled his shadow cover to allow time for Mr Fratson to review Patient A's records and conduct this review. However, Mr Fratson put his wishes above Patient A who was a vulnerable patient and subsequently took her own life.

The panel determined that Mr Fratson deliberately concealed certain information from his colleagues by giving partial accounts of what was instructed of him, and falsified the Lorenzo entry in order to justify his actions. Mr Fratson spoke with Patient A in a corridor, instead of the room provided, taking no account of her dignity and/or vulnerability.

Mr Fratson ignored a clear instruction, was less than candid with his colleagues and failed to undertake any enquiry of Patient A and simply sent her away. It appears to the panel that he did this to avoid doing the work so that he could go home early.

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

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on 'Impairment' (Reference: DMA-1) in which the following is stated:

'The question that will help decide whether a professional's fitness to practise is impaired is:

"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"

If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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/their fitness to practise is impaired in the sense that S/He/They:

- 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 all four limbs of *Grant* are engaged in Mr Fratson's case.

The panel finds that Patient A was put at unwarranted risk of harm given the findings identified in the expert's report. The expert's report stated that Mr Fratson's actions on 27 April 2016, were a material contribution to the subsequent suicide of Patient A. With regards to whether Mr Fratson's actions are liable in the future to cause unwarranted risk of harm, the panel considered all the evidence in the round. It noted that when asked what he would do differently, Mr Fratson told Witness 4 that he would have '*taken her into a room*' to apologise and to send her away, but not that he would have conducted any form of re-assessment. In light of this, the panel was not satisfied that Mr Fratson's actions would not be repeated in the future and this showed very limited insight on his part.

The panel was also of the view that Mr Fratson's actions in the past brought the profession into disrepute. Mr Fratson did not heed Colleague 1's instructions and failed to re-assess a vulnerable patient in his care. Mr Fratson has also deflected responsibility and sought to blame others, which the panel concluded is attitudinal in nature.

As a result, in the absence of any insight, remorse and acceptance of his failings, the panel determined that Mr Fratson's misconduct had breached fundamental tenets of the nursing profession and thereby brought its reputation into disrepute.

The panel was also satisfied that Mr Fratson's dishonesty was directly linked to his clinical practice. It noted that it was not credible that Mr Fratson, a nurse of 17 years' experience in mental health nursing, would not take appropriate steps to re-assess a patient, despite instructions from his Senior Colleague that this was required.

The panel noted that Mr Fratson has not worked as a nurse since the incident. He has not taken responsibility for his failings and he has provided the NMC with no evidence of strengthened practice, training or reflections about the regulatory concerns. In the absence of this, the panel determined that the conduct is likely to be repeated. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

Because Mr Fratson's actions were in connection with the (lack of) care of a highly vulnerable individual, the panel determined that a finding of impairment on public interest grounds is required to protect the reputation of the profession and uphold and declare public confidence in the profession.

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

Representations on sanction

The NMC submitted that a striking off order is the appropriate sanction in the case of Mr Fratson.

The NMC identified the following aggravating factors:

- Attitudinal concerns.
- Lack of insight.
- Lack of remorse.
- No responsibility taken for what occurred.
- Caused a loss of chance of survival.
- Dishonesty in a clinical context.

The NMC did not identify any mitigating factors.

The NMC submitted that taking no action would not be appropriate in this case due to the seriousness of Mr Fratson's lack of insight and his lack of cooperation with the NMC. The NMC also submitted that a caution order would also not be appropriate because it would not mark the seriousness and would be insufficient to protect the public.

The NMC referred to the NMC Guidance: *Conditions of practice order* (SAN-3c) and (FTP-3a). The NMC submitted that conditions of practice would not address the concerns because it cannot be said that there is no evidence of deep-seated attitudinal concerns. Mr Fratson is also not currently showing any insight or willingness to respond positively to retraining.

The NMC next referred to the NMC Guidance: *Suspension order* (SAN-3d) which outlines where a suspension order may be appropriate. They submitted that given the seriousness of the charges and outcome, there is a risk to patient safety if Mr Fratson were allowed to practise following a period of suspension. The NMC say there is disengagement, lack of insight and no demonstration of remorse. In light of this, the NMC submitted that a suspension is not an appropriate sanction.

The NMC submitted that the case raises fundamental concerns about Mr Fratson's professionalism and in light of the attitudinal issues, a striking off order is the only sanction that would protect the public and ensure public confidence in nurses is maintained.

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 Fratson off the register. The effect of this order is that the NMC register will show that Mr Fratson 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.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Attitudinal concerns.
- Lack of insight.
- Lack of remorse.
- No responsibility taken for what occurred.
- Caused a loss of chance of survival.
- Dishonesty in a clinical context.
- Conduct which put people receiving care at risk of suffering harm.

The panel did not identify any mitigating factors.

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

The panel next considered whether placing conditions of practice on Mr Fratson's 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 Fratson's 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;*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. There was evidence of harmful attitudinal problems, and the panel was not satisfied that Mr Fratson had insight and did not consider that he did not pose a significant risk of repeating his behaviour.

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 Fratson's 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 Fratson's 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.

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. The panel decided that the facts found proved, and the breach of fundamental tenets raised questions about Mr Fratson's professionalism. The panel decided that public confidence in nurses could not be maintained if Mr Fratson was not removed from the Register. The panel decided that a striking-off order was the only sanction which was sufficient to protect patients and to maintain professional standards.

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

This will be confirmed to Mr Fratson in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Fratson's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC. The NMC submitted that if a finding is made that Mr Fratson's fitness to practise is impaired on a public protection and public interest basis and a striking off order is imposed, they invite the panel to impose an 18 month interim suspension order. The NMC submitted that it is necessary for the protection of the public and is otherwise in the public interest.

Decision and reasons on interim order

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

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

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

That concludes this determination.