# Section 29 Case Meeting

**29 November 2021**

**157-197 Buckingham Palace Road, London SW1W 9SP**

## Deborah Ellen Sharples

***Members present***
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Simon Wiklund, Head of Legal (Senior Solicitor), Professional Standards Authority
Graham Mockler, Assistant Director of Scrutiny and Quality (Performance), Professional Standards Authority

***In attendance***
David Hopkins of counsel, 39 Essex Chambers

***Observers***
Remi Gberbo, Lawyer, Professional Standards Authority
Michael Hannah, Scrutiny Officer, Professional Standards Authority

### 1. Definitions

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the Authority, together with any abbreviations used specifically for this case are set out in the table at Annex A.

### 2. Purpose of this note

2.1 This meeting note records a summary of the Members' consideration of the relevant decision about the Registrant made by the regulator's panel, and the Authority's decision whether or not to refer the case to the court under Section 29 of the Act.

### 3. The Authority's powers of referral under Section 29 of the Act

3.1 The Authority may refer a case to the relevant court if it considers that a relevant decision (a finding, a penalty or both) is not sufficient for the protection of the public.

3.2 Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:

- to protect the health, safety and well-being of the public
- to maintain public confidence in the profession concerned, and
- to maintain proper professional standards and conduct for members of that profession.

3.3 This will also involve consideration of whether the panel's decision was one that a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could not reasonably have reached; or was otherwise manifestly inappropriate having regard to the safety of the public and the reputation of the profession (applying *Ruscillo*[1]).

## 4. Conflicts of interest

4.1 The Members did not have any conflicts of interest.

## 5. Jurisdiction

5.1 Counsel confirmed that the Authority had jurisdiction to consider the case under Section 29 of the Act. Any referral in this case would be to the High Court of Justice of England and Wales and the statutory time limit for an appeal would expire on 3 December 2021.

## 6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 27 September 2021.

6.2 The Panel's Determination which includes the charges and findings is set out at Annex B.

## 7. Documents before the meeting

7.1 The following documents were available to the Members:

- The Authority's Detailed Case Review
- Counsel's Note dated 25 November 2021
- Determination of the panel dated 27 November 2021
- Transcripts of the hearing dated 20 September 2021 – 27 September 2021
- Regulator's bundle
- Regulator's exhibit log
- Registrant's response bundle
- Case Examiners' Investigation completion report
- Case Examiners' decision letter
- The NMC's Code: Professional standards of practice and behaviour for nurses and midwives 2015 (updated in 2018)
- The NMC's Indicative Sanctions Guidance last updated in October 2018

[1] CRHP v Ruscillo [2004] EWCA Civ 1356

- The Authority's Section 29 Case Meeting Manual.

7.2 The Members were provided with a copy of a response from the NMC to the Authority's Notification of Section 29 Meeting. The Members considered the response after they reached a conclusion on the sufficiency of the outcome for public protection.

## 8. Background

8.1 The Registrant was employed as staff nurse at a care home.

8.2 A referral was made to the NMC on 28 June 2019 by the care home. The referral was made following complaints that the Registrant had inappropriately restrained an 85-year-old resident suffering from dementia.

8.3 It was alleged that the Registrant had:

- Held the resident's wrist and/or wrists
- Stamped on/or stood on the resident's foot
- Held the resident's upper arms
- Pushed the resident
- Grabbed the resident's leg and/or legs
- Prevented the resident from leaving their room.

8.4 The Panel found the allegation proved and that the facts proved amount to misconduct. The Panel found the Registrant's fitness to practise to be impaired and imposed a suspension order for 12 months with a review hearing.

## 9. Applying Section 29 of the 2002 Act

9.1 The Members considered all the documents before them and received legal advice.

9.2 The Members discussed the following concerns about the decision:

### Did the allegation include all potential charges?

9.3 The Panel identified potential misconduct that had not been charged. That being that the Registrant had pushed the resident face down on her bed, which the Panel considered would have been a frightening and humiliating experience for her.

9.4 The Members discussed whether the Panel should have amended the allegation to include this charge. However, the Members noted that the Panel had, in effect, taken this into account when identifying as an aggravating factor that the misconduct caused both emotional and physical harm to a resident who was at higher risk of injury from rough handling.

9.5 The Members concluded that this potential misconduct not being charged did not appear to result in a lesser sanction and therefore was unlikely to have made a material difference to the outcome of the case.

### Did the Panel properly assess the aggravating and mitigating factors?

9.6 The aggravating features identified included the Registrant's lack of insight, the emotional and physical harm caused to a vulnerable elderly resident, the Registrant's seniority and that she should have been acting as a role model to junior staff and that she had been trained on the Restraint Policy and Abuse against Residents Policy.

9.7 The mitigation identified was that there were no previous regulatory findings against the Registrant prior to the incident and two positive references from fellow registrants and one from the relative of a resident describing the Registrant as 'caring and kind'.

9.8 The Members considered that generally the correct aggravating and mitigating features had been identified, however had concerns about how they were applied.

9.9 The Members considered the aggravating features to be serious and that they outweighed the mitigating features significantly. The Members noted that the Panel had found the Registrant to have acted deliberately in retaliation and therefore greater weight should have been given to the emotional and physical harm caused. Had the Panel given appropriate weight to the aggravating factors against the mitigating factors, in the Members' judgement, it would have concluded that a striking-off order was the only appropriate sanction.

9.10 The Members concluded, therefore, that the Panel should have outlined how it factored the aggravating and mitigating features into its decision on sanction. However, in the Member's judgement, there is a lack of clarity in the determination as to how the aggravating and mitigating features were weighted.

### Was the Panel's finding that there was no evidence of a deep-seated attitudinal problem reasonable?

9.11 The Members were concerned with how the Panel approached the question of whether the Registrant had a deep-seated attitudinal problem.

9.12 The Members noted that the Panel appeared to give a great deal of weight to the fact that a manager at the care home was unaware of bullying and to the positive testimonials provided on behalf of the Registrant. However, other witnesses gave evidence that the Registrant was unpleasant to work with and was at times spiteful towards colleagues and residents.

9.13 Moreover, the Members considered that the facts proved, in themselves, were evidence that the Registrant has a deep-seated attitudinal problem; it was wrong for the Panel to conclude there was no evidence of a deep-seated attitudinal problem. However, the panel appeared to consider separately whether there was evidence of an attitudinal problem.

9.14 The Members concluded that attitudinal failings were central to the exercise the Panel had to carry out and that the Panel failed in its assessment of the Registrant's attitude, both from the point of view of its approach and the conclusion it reached.

### Did the Panel properly consider whether the Registrant's misconduct was fundamentally incompatible with her remaining on the register?

9.15 The Members noted that the Panel did consider whether the Registrant's misconduct was fundamentally incompatible with continued registration; reference was made to this at the sanction stage of the determination. However, the Panel's consideration of this point was brief.

9.16 In the Members' judgement, the misconduct was particularly serious, the Registrant did not engage with the proceedings and there was no evidence of insight and remediation. Therefore, the panel ought to have outlined what it weighted against the serious misconduct to conclude that it was not fundamentally incompatible with continued registration.

9.17 The Members concluded that, because the Panel did not outline in detail what factors were weighed against the serious misconduct, it was difficult to understand how it reached the conclusion it did on the issue of fundamental incompatibility.

### Was the Panel's approach to the potential for the Registrant to remediate her misconduct unsupported?

9.18 The Members were concerned the Panel reached the conclusion that *a member of the public fully aware of all the facts may think that if a nurse was able to demonstrate that they had developed full insight shown remorse and remediated, that it was in the public interest for such a nurse to be returned to practice* without any evidence that the Registrant had reflected or undertaken any remediation, or that the Registrant would develop full insight, show remorse and remediate in the future.

9.19 The Members noted that the Panel, in concluding that conditions of practice were not an appropriate sanction in this case, had identified no evidence that the Registrant would engage positively with training or any conditions. This appeared to contradict the Panel's conclusion that there was a possibility of the Registrant developing insight during the 12 months she is to be suspended.

9.20 The Members concluded that the Panel made an aspirational statement about what might happen, which was beyond its role and the information before it. The Panel appeared to give the Registrant the benefit of the doubt when there was no justification for doing so.

### Did the Panel give appropriate weight to the importance of maintaining public confidence in the profession and upholding professional standards?

9.21 The Members noted that public interest factors were central to the case and, therefore, considered that the Panel had a responsibility to outline in detail how

a suspension order adequately addressed the public confidence in the profession and proper professional standards.

9.22 In the Members judgement, the Panel did not adequately address the specifics of this case and how a suspension order adequately addressed the lack of evidence of insight and remediation. The Members were concerned that the Panel appeared to consider a hypothetical question, that being what a member of the public might think if the registrant had reflected and remediated.

9.23 The Members concluded that, while there was reference in the determination to public interest factors having been considered, it was unclear how those factors were weighted.

### Did the Panel have proper regard to the relevant NMC guidance?

9.24 The Members noted that reference was made to the relevant guidance in the determination, however, that this was brief. Therefore, the Members were concerned with whether the Panel had actually engaged with the guidance or merely referenced it.

9.25 The Members considered that the relevant factors outlined in the guidance which suggest that a striking-off order would be appropriate were present in this case; based on the guidance, in the Members' judgement, a striking-off order should have been made. The Members noted that the panel had not provided any reasons for departing from the guidance.

9.26 The Members concluded that there was nothing in the guidance to suggest that the mitigating factors identified in this case negate the seriousness of the misconduct. Moreover, the Members concluded that the guidance does not suggest an approach whereby the Panel should consider a hypothetical question regarding what the public might think if the Registrant showed a willingness to reflect and remediate in the future, particularly when there was no evidential foundation.

### Conclusion on insufficiency for public protection

9.27 The Members concluded that the panel's decision to impose a suspension order for 12 months was insufficient for public protection.

9.28 The Members concluded that the Panel's decision on whether the Registrant had an attitudinal problem was wrong and, therefore, its approach thereafter was flawed.

9.29 The Members were concerned that the Panel identified appropriate and relevant considerations but did not weight them appropriately.

## 10. Referral to court

10.1 Having concluded that the panel's Determination was insufficient for public protection, the Members moved on to consider whether they should exercise the Authority's discretion to refer this case to the relevant court.

10.2 In considering the exercise of the Authority's discretion, the Members received legal advice as to the prospects of success and took into account the need to use the Authority's resources proportionately and in the public interest.

10.3 The Members considered that, based on the information that was before the panel it was not reasonably open to it to impose a suspension order. This was a case of intentional physical harm caused to a vulnerable patient and it was not open to the Panel to determine that the Registrant might reflect on the concerns and remediate the misconduct while suspended; there was no evidence to support that the Registrant would take to opportunity to remediate the misconduct.

10.4 Taking into account those considerations, along with advice on the prospects of success, the Members agreed that the Authority should exercise its power under Section 29 and refer this case to the High Court of Justice of England and Wales.

**05/01/22**

**Alan Clamp (Chair)** **Dated**

## 11. Annex A – Definitions

11.1 In this note the following definitions and abbreviations will apply:

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| **The Authority** | The Professional Standards Authority for Health and Social Care |
| **The Panel** | A Fitness to Practise Committee of the Nursing and Midwifery Council |
| **The Registrant** | Deborah Ellen Sharples |
| **The Regulator** | Nursing and Midwifery Council |
| **NMC** | Nursing and Midwifery Council |
| **The Act** | The National Health Service Reform and Health Care Professions Act 2002 as amended |
| **The Members** | The Authority as constituted for this Section 29 case meeting |
| **The Determination** | The Determination of the Panel sitting on 20 – 27 September 2021 |
| **The Court** | The High Court of Justice of England and Wales |
| **The Code** | Professional standards of practice and behaviour for nurses and midwives 2015 (updated in 2018) |
| **The SG** | The Nursing and Midwifery Council's Sanctions Guidance last updated in October 2018 |