Section 29 Case Meeting

07 September 2021

157-197 Buckingham Palace Road, London SW1W 9SP

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Mark Stobbs, Director of Scrutiny and Quality, Professional Standards Authority
Kisha Punchihewa, Head of Legal, Senior Solicitor, Professional Standards Authority

In attendance
David Bradly of counsel, 39 Essex Chambers

Observers
Remi Gberbo, Lawyer, Professional Standards Authority
Rebecca Senior, Senior Legal Reviewer, Professional Standards Authority
Michael Hannah, Scrutiny Officer, Professional Standards Authority
Collette Byrne, Accreditation Officer, Professional Standards Authority
Seun Fagbohun, Data Administrator, 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 9 September 2021.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on [redacted].

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:

- Determination of the panel dated [redacted]
- Counsel's Detailed Case Review
- Transcripts of the hearing dated [redacted]
- Opening Note prepared by Counsel for the Regulator
- Chronology prepared by Counsel for the Regulator
- Case Examiners' Decision letter dated [redacted]
- Case Examiners' Investigation Report and bundle dated [redacted]
- Approved Judgement of the Family Court dated [redacted]
- The Regulator's bundles and exhibits
- Hearing decision letter dated [redacted]

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

- The Regulator's Code: Standards of Conduct, performance and ethics for nurses and midwives 2008
- The Regulator's Indicative Sanctions Guidance 28 January 2016
- The Authority's Section 29 Case Meeting Manual

7.2 The Members were provided with a copy of a response from the Regulator to the Authority's Notification of s.29 Meeting.

8. Background

8.1 The Registrant was employed as a Registered Nurse at [redacted] NHS Foundation Trust.

8.2 The Registrant was referred to the Regulator on [redacted] by [redacted] NHS Foundation Trust because she was the subject to a child safeguarding investigation and Family Court proceedings.

8.3 The case was put before a Panel in [redacted]; the Allegation consisted of two particulars: - (i) statements allegedly made about a patient under the Registrant's care and was found not proved; and (ii) actions leading to the deliberate harming of Baby X.

8.4 The NMC offered no evidence in relation to particular 2 on the basis that the NMC did not have medical records to prove that Baby X had sustained injury and that the Family Court had not been able to identify positively the perpetrator of the injuries. The NMC did not make an application to obtain the documents before the Family Court because it considered that such an action would be "disproportionate".

8.5 The Panel accepted the submission that there was no case to answer in relation to particular 2.

8.6 The Authority appealed the [redacted] Panel's decision to the High Court of England and Wales on the basis that the NMC failed, in relation to particular 2, to (i) properly investigate, and then to put before the Panel material in the NMC's possession which indicated that the registrant bore some responsibility for significant injuries to Baby X; and (ii) put before the Panel evidence in relation to particular 2 to the allegation.

8.7 The High Court, having heard the appeal, ordered that the case be remitted to a differently constituted Panel for a full hearing of particular 2, with directions that:

- the NMC reconsider whether further evidence should be obtained in support of particular 2 and,
- if it is determined that further evidence should be obtained in relation to particular 2, that the NMC use its best endeavors to obtain that evidence.
- The NMC may amend particular 2 in light of the evidence available.

In any event, the NMC shall present all the available evidence in relation to particular 2 to the newly constituted Panel.

8.8 At the remitted hearing in [redacted] the Panel considered amended charges alleging

- that, on one or more occasions in [redacted], having observed or been informed of marks and/or bruises on Baby X, the Registrant did not seek medical attention or take Baby X for a blood test, as had been suggested by a General Practitioner.
- that the Registrant's actions as alleged under particular 1 failed to protect her child.
- that, in [redacted], the Registrant incorrectly told a Social Worker that she had not undertaken any work in a nursing or caring capacity whilst suspended from her current position. Furthermore, that she instructed her solicitors to inform the local authority that she had not worked as a nurse in [redacted].
- that the Registrant's actions as alleged under particular 3 were dishonest because she knew she had undertaken work as a nurse in [redacted].

8.9 The Panel found the Allegation proved in its entirety, by way of full admissions made by the Registrant at the outset of the hearing. It determined that the facts found proved amounted to misconduct but that the Registrant's fitness to practise is not currently impaired.

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:

Had the NMC particularised the allegation correctly?

9.3 The Members first considered whether the allegation was appropriately particularised. The allegations before the panel concerned the Registrant's failure to act having observed and/or been informed of bruising and/or marks on Baby X as well as an allegation of dishonesty. The concerns about potentially causing injury to Baby X had not been particularised as required by Order of the Court.

9.4 The Members noted that NMC had obtained a copy of the [redacted] Family Court judgment and it could be seen that the Family Court judge was unable to determine who was responsible for the injuries to Baby X; the information available to the Court demonstrated that either parent could have caused the injuries, but it could find only that each parent is potentially individually responsible and that it could not have been both parents.

9.5 In addition, the Judge accepted expert evidence that even a medically trained person may not have detected the baby's injuries and, therefore, that there was no failure to protect on the part of the parent who did not inflict the injuries.

9.6 The Judge did find that there were failings to protect in relation to bruising and/or marks on the baby's body.

9.7 On the basis of this detailed judgment, the Members were satisfied that, following remittal of the case by the High Court, the NMC had now investigated the potential concerns about the harm caused to Baby X and particularised the allegation correctly. The Members noted that it was not the role of the NMC of the Authority to seek to resolve what the Family Court was unable to resolve, particularly after [redacted].

Was the Panel correct to make a finding of no impairment?

9.8 The Members went on to consider whether it was appropriate for the Panel to find that the Registrant's fitness to practise is not currently impaired.

9.9 It was noted that the facts found proven were serious with the potential to raise serious concerns about the Registrant's fitness to practise.

9.10 However, the Members also noted that the misconduct took place over seven years ago with no evidence of repetition. The Registrant had demonstrated to the Panel that she had reflected on her conduct, she provided testimonial evidence to the panel, which attested to the Registrant's good character and showed that she understands the importance of safeguarding.

9.11 On the basis of the charge before it, and taking into account the passage of time, insight and remorse shown by the registrant the Members concluded that it was not unreasonable for the panel to make a finding of no current impairment.

9.12 The Members reflected that the purpose of the original appeal was to address the flaws in the NMC's investigation and the procedural errors at the hearing.

Conclusion on insufficiency for public protection

9.13 The Members concluded that, in all the circumstances, the Panel's decision was not insufficient for public protection.

10. Referral to court

10.1 Having concluded that the panel's Determination was not insufficient for public protection, the Members were not required to consider whether they should exercise the Authority's power under Section 29 to refer the case to the relevant court.

11. Learning points

11.1 The Members agreed that the learning points set out at Appendix C should be communicated to the Regulator.

04/10/21

Alan Clamp (Chair) **Dated**

12. Annex A – Definitions

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

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	The Fitness to Practise Committee of the Nursing and Midwifery Council
The Registrant	
The Regulator	The Nursing and Midwifery Council
NMC	The 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
The Court	The High Court of Justice of England and Wales
The Code	The Nursing and Midwifery Council Standards of Conduct, performance and ethics for nurses and midwives 2008
The ISG	The Nursing and Midwifery's Indicative Sanctions Guidance approved May 2012 and revised January 2016