Neutral Citation Number: [2018] EWHC 70 (Admin)

Case No: CO/3963/2017

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19/01/2018

Before :

MRS JUSTICE ELISABETH LAING DBE

- -

Between :

PROFESSIONAL STANDARDS FOR HEALTH AND SOCIAL CARE	**Appellant**
- and -	
NURSING AND MIDWIFERY COUNCIL	**First Respondent**
- and -	
X	**Second Respondent**

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- -

Mr David Bradly (instructed by **Capsticks**) for the **Appellant**
Miss Helen Fleck (instructed by **NMC**) for the **First Respondent**
The **Second Respondent** did not appear and was not represented.

Hearing dates: 14 December 2017

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Approved Judgment

Mrs Justice Elisabeth Laing DBE :

Introduction

1. This is my decision on an appeal by the Appellant, the Professional Standards Authority for Health and Social Care ('the PSA'), against a decision of the Nursing and Midwifery Council, the First Respondent ('the NMC'). The Second Respondent is a registered nurse and the mother of Baby A. The Second Respondent indicated before the hearing that she did not intend to oppose the appeal, but that she did want the hearing to be in private.

2. At the start of hearing, I decided that the appeal should be heard in public, but I made an order preventing the publication of any matter which might lead to the identification of the Second Respondent, as the material allegation in this case concerned non-accidental injuries to her baby, Baby A. In my judgment steps to anonymise the Second Respondent and her baby struck an appropriate balance between open justice, and the protection of the interests of Baby A. I have also been careful in this judgment not to identify any of the people, entities or places involved in the events which are the background to the appeal. Those steps being possible, and, it seems to me, likely to be effective, it would have been wrong to hear the appeal in private.

3. The Appellant was represented by Mr Bradly, and the NMC by Miss Fleck. I am grateful to both counsel for the written and oral submissions and to them and to their teams for the evident preparation which they had done for the hearing.

4. The appeal is brought under section 29 of the National Health Service Reform and Health Professions Act 2002 ('the 2002 Act'). It is an appeal against a decision of the Conduct and Competence Committee of the NMC ('the Committee'), notified to the Second Respondent on 10 July 2017, that there was no case for her to answer in respect of particular 2 of an allegation that her fitness to practise as a nurse was impaired by reason of her misconduct.

The facts

5. This narrative is based mostly on the report produced by a Serious Case Review ('the Report'), and in part on an investigation report ('Report 2') by the NHS Trust which employed the Second Respondent ('the Employer'). The NMC had both these documents, so the information in them was available to the NMC. They are apparently reliable, neutral documents. The NMC did not suggest, either in the documents I have seen, or in the course of the hearing, that there was any reason to doubt their reliability. It follows, in my judgment, that, in the absence of any contradicting material, these documents should have influenced the NMC's analysis of the issues, at least as a starting point.

6. The Second Respondent did agency shifts for the Employer between December 2013 and January 2014, when she went on maternity leave. Baby A was born on 15 January 2014, by caesarean section. The Second Respondent was in due course employed by the Employer in a substantive post from 31 March 2014. She was absent from work with stress and anxiety between 23 April 2014 and 26 June 2014. It seems that the Second Respondent did not return to work as an employee of the

Employer (as opposed to doing agency shifts for an unknown entity) before 31 March 2014 (see the Employer's notes of the disciplinary hearing on 5 June 2015). It seems that after 31 March 2014, the Second Respondent was 'mainly working weekends to suit childcare arrangements' (ibid).

7. According to her statement to the police, the second respondent went back to work on 5 February 2014, when Baby A was three weeks old, working two long agency shifts per week; this does not appear to have been full-time employment with the Employer. She did not tell any health professional that she was going back to work so soon after a caesarean section. She had been prescribed painkillers by her GP for post-operative pain only two days previously. She contacted the Employer and asked to go back to work when Baby A was six weeks old.

8. On 4 March 2014, the Second Respondent reported two little bruises on Baby A's face to a health visitor ('HV1'). HV1 was a student health visitor. HV1 could not see the bruises, but noted that Baby A had lost weight. The Second Respondent reported that she had consulted her GP about this bruising and that a blood disorder was being considered; she reported that the test was quite traumatic and the problem would probably resolve itself. She had not, in fact, had such a conversation with her GP ('factor 1').

9. On 13 March the Second Respondent reported bruises on Baby A to her GP ('GP3'). GP 3 noted a very faint bruise on Baby A's right knee. There was a discussion whether a blood disorder could be a possible cause. The Second Respondent was advised to take Baby A to an out-patients' clinic for a blood test as soon as possible. She was given the appropriate form. The Second Respondent did not follow this advice ('factor 2').

10. On 14 March the Second Respondent reported bruises on Baby A to HV1. HV1 noted two faint bruises on Baby A's knees.

11. On 11 April the Second Respondent reported bruises on Baby A to a health visitor ('HV2') at a baby clinic appointment. She said that she had not taken Baby A for a blood test because of family circumstances. She also said that she and her partner had split up. She was later to tell the police, during the police investigation, that she had assaulted her partner during the course of their relationship. HV2 did not see any bruises but arranged for the Second Respondent to see a GP the same day. It is does not seem as though the Second Respondent did see a GP that day; such a visit is not referred to in the documents I have seen, although a visit to a GP on 16 April is mentioned. HV2 also arranged a home visit, for the following week, as she felt uneasy about the way the Second Respondent had behaved during the appointment, but the Second Respondent cancelled it ('factor 3').

12. On 17 April, a health visitor ('HV3') reviewed the Second Respondent's notes. HV2 advised HV3 to contact the GP for the outcome of the Second Respondent's visit to the GP on 16 April. HV3 rang the Second Respondent on 17 April to ask about the visit to the GP. The Second Respondent reported that the GP was not unduly worried about Baby A's weight loss, and wanted to see Baby A in a month's time. HV3 asked GP1 what advice had been given about bruising. GP1 said blood tests were being considered but GPS was not unduly worried. GP1 had not seen any bruising. GP1

told HV3 to refer to back to the GP if any further bruises were seen. GP1 acknowledged a drop in Baby A's weight.

13. HV3 rang the safeguarding nurse advisor ('the SNA'). The SNA felt that a referral to social services would increase the Second Respondent's anxieties. At that point, Baby A was putting on weight, seemed happy and well, and the GP was not worried. Also on 17 April, HV3 agreed with the supervising health visitor ('HV2') that there would be a home visit on 22 April.

14. On 22 April 2014, the Second Respondent reported a bruise on Baby A's chin to her GP ('GP1'). She had been urgently referred to the GP by a health visitor ('HV2') because HV2 was worried about bruising and about Baby A's weight; which was increasingly slightly by then. GP1 did not weigh Baby A. The Second Respondent mentioned a bruise which was difficult to see. GP1 was worried that the Second Respondent had not taken Baby A for blood tests, and planned to ring the on-call consultant after surgery hours. On the same day, Baby A was admitted to hospital for assessment, not, apparently, as a result of anything the Second Respondent did, but because a health visitor had reported her concerns to paediatricians at the hospital ('factor 4').

15. Baby A was 14 weeks old. Baby A had injuries which were 'significant injuries…diagnosed as non-accidental in nature'. Baby A was so young that Baby A was not independently mobile. Repeated reports of bruising would raise questions about how the bruises were sustained ('factor 5').

16. More serious questions are raised by the injuries which were described in the review ('the Review') by a paediatric radiologist who examined the relevant x-rays. A full skeletal survey on 23 April 2014 suggested the possibility of healed or healing rib fractures and a small corner fracture of a leg. The Review on 28 April 2014 reported 3 healing rib fractures on the fourth, fifth and sixth ribs, which had been suffered between 4 and 6 weeks previously and four distinct fractures to four different bones in each of Baby A's legs which had been suffered 2-4 weeks previously ('factor 6').

17. As the Report noted, 'It appears from the [Review] that [Baby A] first sustained injuries at approximately 6 weeks of age and remained in an extremely unsafe situation, sustaining further injuries, for a further 10 weeks before [Baby A] was removed from the situation' (paragraph 8.1).

18. On 5 July 2014, the Employer suspended the Second Respondent pending the outcome of a police investigation. On 8 August 2014, the Employer referred the Second Respondent to the NMC.

19. In December 2014, there was a fact-finding hearing in the Family Court. The hearing lasted 12 days, according to the NMC's documents. The Court gave an ex tempore judgment. It found, in summary, that both parents were potential perpetrators of Baby A's injuries. Both were found to have failed to protect Baby A. There was a psychological assessment of the Second Respondent before the Family Court which was said to raise potential issues about her fitness to practise ('factor 7').

20. On 2 April 2015, the Employer was told that the police investigation had concluded that there was not enough evidence to 'pursue a case to determine the actual perpetrator/s of harm'.

21. On 8 April 2015, the Second Respondent's Employer told her that it was to hold a disciplinary hearing in her case. The hearing was later re-scheduled. On 29 May 2015, the Second Respondent wrote a letter of resignation. She said that the allegations against her were 'untrue', but she felt that the Employer had already made its mind up to terminate her contract for gross misconduct. She said it was unfair of the Employer to say that she had failed to protect Baby A. 'The judge may have ruled this in the family court, with the evidence she had, due to health professionals who saw my son lying on oath, but I have not been found guilty of any crime in any criminal court, nor will I be' ('factor 8').

22. On 3 June 2015, the NMC wrote to the Family Court. The NMC referred to its statutory functions and to the fact-finding hearing in December 2014. It asked for a transcript of the hearing, a copy of the judgment, and a copy of the report about the Second Respondent by a named psychologist. It did not ask for a copy of the Review or for any other medical evidence. The letter referred to the NMC's view that the documents were disclosable under the Data Protection Act 1998 and to its power, conferred by article 25 of the Nursing and Midwifery Order 2001, 2002 SI No 253 ('the 2001 Order') to require any person to produce a document which appears relevant to the discharge by the NMC of any of its functions. Disclosure of the documents, said the NMC, was 'necessary to enable the NMC to exercise its statutory functions, namely it will help to make a decision as to [the Second Respondent's] fitness to practise as a nurse *given the seriousness of the concerns raised*' [my emphasis].

23. On 15 June 2015 the Employer held a disciplinary hearing. The Second Respondent did not go to it, and so did not take that opportunity to put forward her case ('factor 9'). On 15 June 2015, the Second Respondent's Employer dismissed her for failing to protect Baby A.

24. Also on 15 June, HM Courts and Tribunal Service ('HMCTS') replied to the NMC's letter. The designated family judge had discussed the NMC's letter with the trial judge. The letter said that family proceedings are confidential. In order to comply with the NMC's request, it would be necessary to have a hearing on notice to all the parties to the family proceedings. The court 'is happy to facilitate this on your submitting an application' but it was not happy to release papers without a formal application and supporting arguments. There was no written judgment on the website, but an indication of the cost of a transcript could be got from the official court transcribers (their name was provided).

25. There was then an investigation by the NMC's investigators. They prepared a report ('the Investigation Report') for the NMC's Case Examiners in September 2016. The investigators considered several documents, including the Report and Report 2. The Investigation Report said that one of the factual issues was whether the Second Respondent was 'wholly or partly responsible for non-accidental injuries to [Baby A] and/or did not protect [Baby A] from harm on unknown dates around March/April 2014'.

26. The Investigation Report, wrongly, in three different passages, asserted that the family court would not release documents unless all the parties consented. In the first of those passages, the investigators said that they 'were unable to obtain further information from the Family Court namely the Psychology Report…and a copy of the Judge's summation of the Finding of Fact Meeting [sic]'. That is said to be 'evidenced' by a letter from HCMTS 'confirming that these documents can only be disclosed by order of the court and with the consent of the interested parties. This is not a feasible or proportionate course of action for the NMC to take at this juncture'. Supposing for a moment, against the facts, that any consent had been required, there is no suggestion that the NMC had even asked anyone for their consent or that consent had been withheld by anyone, before the NMC had concluded that further efforts to get the documents were neither 'feasible' nor 'proportionate'.

27. The investigators said that the Second Respondent had not given a formal response to the NMC but that 'we do have an indication from [the Second Respondent's] resignation letter that she denies the allegations relating to [Baby A]'. The investigators did not refer to the Second Respondent's accusation that the health professionals who saw Baby A 'lied on oath' to the Family Court. The investigators said that the Second Respondent had engaged with the NMC process by attending the IO [that is, Interim Order] hearing on 4 August 2015. She had denied the allegations about Baby A apart from admitting that she had not taken Baby A to one blood test, though that was 'the same day she took [Baby A] to Accident & Emergency'. It is far from clear that that second assertion was accurate, if and in so far as it was intended to imply that the Second Respondent had spontaneously taken Baby A to hospital.

28. The investigators decided that the allegations I describe at paragraph 25, above, were 'factual issues where no case to answer deemed appropriate' [sic], and that they should not, therefore, be referred to the Committee. The reasoning in support of that view is in a box headed 'Description & Rationale'. The investigators referred to a 'two and half week hearing' in the Family Court 'relating to determining the source of non-accidental injuries to' Baby A. The court's conclusion was that the Second Respondent and/or her partner 'were the likely perpetrator of said non-accidental injuries and that they failed to protect' Baby A. The police had investigated and decided to take no further action.

29. The investigators then said that they had 'made attempts' to get the 'the Family Court summation [sic] but these attempts have been unsuccessful'. The investigators referred to the letter dated 15 June 2015, in which, again, inaccurately, they reported to have 'confirm[ed]' that the investigators would need to apply to the court and get the consent of the parties. The Investigation Report was also inaccurate in suggesting that more than one attempt had been made, and to the extent that it implied that the investigators had done any more than write one letter to the Family Court and then give up. The investigators then said that 'this is not a proportionate or feasible action for the NMC to take as the matter does not relate to patient care and [the Second Respondent] does not have a criminal conviction'.

30. This reasoning is unsatisfactory. There are two main reasons.

    i) It is right to say that the allegation did not directly relate to patient care, but wrong to imply that the allegation, if made out, could have no bearing on patient care. I note that the Employer could very clearly see the implications

for patient care, and that is why the Employer dismissed the Second Respondent, as the investigators acknowledged, further down the same box. This error may have been contributed to by the investigators' complete failure to describe, and therefore to consider the implications of, the exact nature of Baby A's injuries, and, it follows, to acknowledge how serious they were. The only injuries the investigators refer to are bruises, creating an impression that the investigators considered that those were the only relevant injuries. The NMC apparently considered when it wrote its letter of 3 June 2016 to the Family Court that its concerns were 'serious'; but there is no reference to their seriousness in the Investigation Report.

ii) The fact that the Second Respondent did not have a criminal conviction is irrelevant. The standard of proof applied by the criminal court is stricter than the civil standard applied by the NMC. There had, in any event, been no trial.

31. Given those two flaws in their reasoning, and given the investigators' erroneous description of their 'attempts' to get the judgment, and of the hurdles which might obstruct any attempt to get the judgment, there is no conceivable justification for the conclusion that it was neither feasible nor proportionate for the NMC to try to get a copy of the judgment of the Family Court (or of the other document requested in the letter of 3 June 2016). That judgment (and the other documents) were highly relevant. The judgment was the assessment by the specialist Family Court, after a 12-day hearing, of the very allegation which the NMC was supposed to be investigating.

32. The Report is dismissed on the basis that it 'focuses primarily on other healthcare professionals' involvement with [the Second Respondent] and [Baby A] and examines communication between different healthcare professionals regarding concerns about unexplained bruising to [Baby A]. The report provides a history of issues affecting [the Second Respondent] and explores missed opportunities to escalate [Baby A] to safeguarding following [the Second Respondent] reporting bruising to [Baby A]. The report does not make any comment as to how [Baby A] sustained his injuries'. This characterisation of the Report suggests that the investigators failed to analyse the events described in the Report, and their obvious potential implications for the Second Respondent's fitness to practise. The Investigation Report does not set out the sequence of events, and, it follows, does not assess the implications of those events.

33. The NMC's Case Examiners then considered whether any allegations about Baby A's injuries should be referred to the Committee. In a letter dated 3 November 2016, they told the Second Respondent that they had considered her case on 31 October 2016 and had decided that she had a case to answer. Their reasons were attached to the letter. They described the allegation as one that the Second Respondent 'bore responsibility directly or indirectly for non-accidental injuries to [Baby A], her own child'. The Case Examiners said of this allegation (and of the others against the Second Respondent) that 'If proven the allegations suggest a risk to people's safety and to the public's confidence in the professions'.

34. The Case Examiners considered all the documents considered by the NMC's investigators, and the Second Respondent's 'apparent responses to the proceedings'. The test they applied was whether there was a real prospect that the Committee could find the Second Respondent's fitness to practise to be impaired. The Case Examiners referred to the apparent conclusion of the 12-day hearing in the Family Court that

'both parents are potential perpetrators and both are guilty of a failure to protect [Baby A]'. They noted that neither parent was prosecuted, but also that Baby A was removed from their care by the relevant local authority. They considered that there was a real prospect of finding proven an allegation that the Second Respondent 'bore some responsibility whether directly or indirectly for the non-accidental harm' to Baby A.

35. I note that the Case Examiners referred to bruising and to 'apparently significant non-accidental injuries'. Like the investigators, however, they did not describe the serious injuries logged in the Review. I also note that they appreciated that the decision of the Crown Prosecution Service to take no further action was not relevant, given the different standard of proof which applies in a criminal prosecution .

36. The hearing by the Committee was on 3 May 2017. The Second Respondent attended the hearing. She gave evidence and was represented by counsel. Charge 2 was 'That you, as a registered nurse in or around April 2014, were directly or indirectly responsible for one or more non-accidental injuries caused to Baby A. And in light of the above, your fitness to practise is impaired by reason of your misconduct'. The part of the hearing which concerned charge 2 was held in private. The exhibit sheet of the transcript of that part of the hearing records that no exhibits were referred to in that part of the hearing.

37. Ms Ling, who represented the NMC, told the Committee that charge 2 did not involve the Second Respondent's practice as a nurse. She said that the NMC had considered charge 2 'very carefully' and had decided to offer no evidence on it. She was going to invite the Committee to 'exercise its discretion to depart from its standard procedure and proceed to consider at the outset whether there is a case to answer' on charge 2. She said that the Second Respondent had been referred to the NMC after she told her ward manager that 'there were allegations regarding potential non-accidental injuries to [Baby A]'. Ms Ling did tell the Committee that Baby A was the Second Respondent's child. Ms Ling told the Committee that the NMC had 'taken consideration of all the available evidence we could obtain and…taken the view, in accordance with the senior lawyers as well, that there is not sufficient evidence to prove this allegation. In effect, the NMC ask [the Committee] to find that there is no case to answer in respect of Charge 2'.

38. She told the Committee that charge 2 arose from 'the outcome of a two-week family court hearing'. The proceedings were 'very confidential' and 'we have been fed through multi-layered hearsay as to what the conclusion of the family court proceedings is, but we are not precise because we are not able to obtain that information as to the exact conclusion'. She then outlined what she described as NMC's difficulties with the case, which had led to the decision to offer no evidence. I say more about what she told the Committee below, when I consider my overall conclusions.

39. The legal assessor acknowledged that the Committee had considered no evidence. She advised them there was no evidence on which they could find the charge proved (which was, it has to be said, obvious, if no evidence was put before the Committee) and that they could accept a submission of no case to answer without having considered any evidence. She also advised them and that that was their only option. In a rather confused passage, she referred to the facts that there was no evidence about

the Family Court proceedings, that no application had been made for that evidence, and that the Committee had 'heard the reasons for why that has not been made in terms of the practicalities of that matter.'

40. The Committee's decision was sent to the Second Respondent in a letter dated 10 July 2017. The decision summarised Ms Ling's submissions, and her invitation to the Committee to 'exercise its discretion to make a finding of no case to answer'. Ms Ling had submitted that the evidence consisted largely of meeting notes and 'other documents…that made reference to injury to [Baby A], but that it did not contain any medical evidence of this, or whether any such injury was non-accidental'.

41. It is notable that the Committee refer at times to 'injury' not 'injuries', and evident that the Committee had no idea of the number, or timing, of the injuries, or of their obvious seriousness. It is also evident that the Committee had not been equipped to reach the self-evident conclusion that given those factors, Baby A's state of physical development, and the lack of any other explanation, the injuries must have been non-accidental. Nor had they been told that they could only have been inflicted by the Second Respondent or by her partner.

42. The Committee summarised what they had been told about the hearing in the Family Court. They recorded a submission that 'as the Family Court was unable to reach a definitive conclusion on who was the perpetrator of Baby A's injuries, it would be unlikely that the [Committee] would be in a position to make a determination on charge 2'. There are two apparent errors in this assessment. First, charge 2 did not require the Committee to find that the Second Respondent had been the 'perpetrator' of Baby A's injuries. The Committee's account of the submissions of Miss Deignan (the Second Respondent's representative) repeats this inaccurate characterisation of charge 2. Second, it seems that the Committee thought that if the Family Court had not been able to reach a definitive conclusion, that disabled, or exempted, the Committee from making its own decision.

43. The Committee uncritically reported Ms Ling's account of the NMC's conclusion that it would be 'disproportionate' to apply to the Family Court for 'further information'.

44. The Committee recorded that it had accepted the advice of the Legal Assessor. It had had regard to 'the evidence currently available to the NMC. Given the position of both parties [a mysterious formula] it is clear that the NMC neither has, nor will be obtaining any evidence in the near future, which would enable a panel, properly directed, to find charge 2 proved'. The decision then said, 'The panel therefore accepted the NMC's proposal to offer no evidence, and determined, pursuant to Rule 23(7) that you had no case to answer'.

The legal framework

The National Health Service Reform and Health Professions Act 2002 ('the 2002 Act')

45. Section 29(4) of the 2002 Act enables the PSA, when a relevant decision, such as this decision by the NMC, is made, to refer the case to the court when it considers that the decision is 'not sufficient…for the protection of the public'. Section 29(4A) explains what that means. When there is such a reference, the court is to treat it as an appeal by the PSA against the relevant decision (section 29(7)). By section 29(7A) a

decision by a Committee of a body such as the NMC is to be treated as a decision by that body. The test to be applied by the court on such an appeal is whether the decision is wrong (CPR 52.11(3)(a)).

46. The court may dismiss the appeal, allow the appeal and quash the relevant decision, substitute for the relevant decision any other decision which could have been made by the committee (or other body concerned), or remit the case to the committee or body for it to dispose of the case in accordance with the court's directions (section 29(8)).

47. I accept Mr Bradly's submissions that where all the material evidence has been put before an expert decision maker such as the Committee, the court should give weight to the Committee's expertise, but that where it has not been, that decision 'will inevitably need to be reassessed' (*Ruscillo v Council for the Regulation of Healthcare Professionals* [2004] EWCA Civ 1356, at paragraph 78). I add that, in my judgment, the extent to which the court will give weight to the views of the Committee is bound to depend on the nature of the decision which the court is reviewing. For reasons which I have already touched on and for further reasons which I give below, I accept Mr Bradly's further submission that this case is not a case in which I should give any weight to the Committee's decision. Mr Bradly also drew my attention to paragraph 80 of *Ruscillo* in which the Court of Appeal said that the disciplinary body should 'play a more pro-active role than a judge presiding over a criminal trial in making sure that the case is properly presented and the relevant evidence is placed before it'.

48. The statutory provisions have been amended since the decision in *Ruscillo*. I am not persuaded by Mr Bradly's submission that *General Medical Council v Jagjivan* [2017] EWHC 1247 (Admin) (Divisional Court) decides that on the points which are material to this case, the approach to the interpretation of the 2002 Act is still as stated in *Ruscillo*. The decision in *Jagjivan* concerns a jurisdictional point only. Nonetheless, Miss Fleck did not submit that the general approach stated in *Ruscillo* was wrong, and I see no reason not to follow it.

The Nursing and Midwifery Order 2001, 2002 SI No 253 ('the 2001 Order')

49. The 2001 Order is made under powers conferred by sections 60 and 62(4) of the Health Act 1999. By article 3(9) of the 2001 Order, the NMC is to have two committees, the Investigating Committee and the Fitness to Practise Committee, together referred to as 'the Practice Committees' (article 3(10)). Article 3(12) gives the NMC power to establish such other committees as it considers appropriate and to delegate any function to them, other than its power to make rules.

50. Part V of the 2001 Order is headed 'Fitness to practise'. Article 25 of the 2001 Order gives a person authorised by the Council power to require any person (other than the registrant) who is, in the opinion of the authorised person, able to supply information or to produce any document which appears relevant to the discharge of any functions in respect of fitness to practise, to supply the information or produce the document.

51. Where an allegation is made against a registrant that his or her fitness to practise is impaired by misconduct (article 22(1)(a)(i)), it must be referred to the NMC's screeners, appointed in accordance with rules made under article rule 23, or to a Practice Committee (article 22(5)). Article 26(2)(d)(i) requires the Investigating Committee to consider, when an allegation of misconduct is referred to it, whether

there is a case to answer. Article 26A of the 2001 Order gives the NMC power by rules to make provision for the exercise by the Registrar, or by any other officer the NMC, of various functions conferred on the Investigating Committee by article 26, including the function conferred by article 26(2)(d)(ii).

52. Article 27 of the 2001 Order requires the Committee to 'consider any allegation referred to it by the Council, Screeners, or the Investigating Committee'. I accept Mr Bradly's submission, which Miss Fleck did not dispute, that in deciding that there is a case to answer and so referring a case to the Committee, the Case Examiners (see the next paragraph) stand in the shoes of the Investigating Committee for the purposes of article 27 of the 2001 Order.

The Nursing and Midwifery Council (Fitness to Practise) Rules Order 2004, 2004 SI No 1761 ('the Rules')

53. The NMC has made the Nursing and Midwifery Council (Fitness to Practise) Rules Order 2004, 2004 SI No 1761 ('the Rules') pursuant to various powers conferred by the 2001 Order. Rule 2 defines 'Case Examiner' as a professional or lay officer of the NMC appointed by the Registrar for the purposes of exercising the functions of the Investigating Committee in accordance with article 26A of the 2001 Order. Rule 2A(2) of the Rules requires the Registrar to refer any allegation which (he or she considers) falls within article 22(1)(a) of the 2001 Order to the Case Examiners for consideration under rule 6C of the Rules. Where the Case Examiners 'agree that there is a case to answer', they must refer the allegation (if it is an allegation of misconduct) to the Committee (rule 6C(2)(a)(ii)).

54. Rule 12 requires the Committee to conduct a hearing in accordance with the procedure set out in Part 5 of the Rules, and to 'dispose of the allegation' in accordance with articles 22(4) and 29(8)-(4) of the 2001 Order. Rule 24 of the Rules requires the Committee 'unless it determines otherwise' to conduct the initial hearing of an allegation 'in the following stages'. Four stages are then described in rule 24(1)(a)-(d). The possible components of each stage are then described in rule 24(2)-(5), (6)-(11), (12), and (13). Some of the components of those stages are mandatory ('shall') and some discretionary ('may').

55. It is sufficient for the purposes of this case, first, to record Mr Bradly's realistic concession that, even though this is not expressly provided for in the Rules, it must be open to the NMC, in an appropriate case, to offer no evidence. I note that the NMC has produced operational guidance about offering no evidence which makes it clear that this course is only appropriate in limited circumstances. None of those circumstances applied in this case. I accept Mr Bradly's further submission that the cases in which it would be appropriate to offer no evidence will be rare.

56. Second, my clear view is that

    i) rule 24(6) requires the NMC to open the case; and

    ii) rule 24(7) and rule 24(8) permit the Committee to accept a submission of no case to answer, but only (1) where the NMC has closed its case, and presented its evidence, and (2) only at the instigation of the registrant, or where the Committee does so 'of its own volition'. It is inherent in a submission of no

case to answer that it can only be made at the end of the Council's evidence. The test in *R v Galbraith* [1981] 1 WLR 1039 can only be applied if a tribunal has considered evidence; if it has not, there is nothing to which that test can applied.

57. I accept Miss Fleck's submission that rule 24(1) gives the Committee power to decide, in an appropriate case, not to conduct a hearing in accordance with the stages set out in rule 24. In my judgment that general power cannot be used to contradict the effect of the specific provisions in rule 24(6), (7) and (8) which I have just described. It follows that that rule 24(1) does not enable the Committee to take short cuts, such as releasing the NMC from its obligation to open the case, or as accepting a submission of no case to answer without hearing any evidence, or at the instigation of the NMC. I consider that it is especially important, if the NMC considers that it is appropriate to offer no evidence, that it fully opens the case, so that the Committee is able to make a decision, informed by a sufficient knowledge of the facts, whether it is appropriate for the NMC to offer no evidence, or whether it should require the NMC to reconsider that view, and try and obtain more evidence. In this case, for reasons which should be clear from what I have said before, and which I elaborate to some extent below, the Committee were not given the information they needed to make a fully informed decision.

Discussion

58. Mr Bradly helpfully opened his case fully, and referred me to the salient relevant documents. As he did so, he made submissions, which, on the whole, I accept, about various flaws in the proceedings. He referred to several factors in the evidence which the NMC had which were not referred to, either by Ms Ling in her submissions to the Committee, or by the Committee in its decision. I have referred to nine such factors in my summary of the facts. There may be more. I accept his submission that such factors were relevant and should have been taken into account by the NMC before it decided to offer no evidence, and by the Committee in its decision. The Committee cannot be criticised not taking them into account, because the NMC did not tell the Committee about them. I consider that no reasonable body, having taken those relevant factors into account, could have concluded that no evidence should be offered, and that, a reasonable Committee which had been informed of those factors (as this Committee had not been), could not lawfully have accepted the NMC's decision to offer no evidence. I have further concerns about the way in which the NMC presented the case to the Committee, which I summarise below, in paragraph 59.

59. I said in paragraphs 38 and 58, above, that I would say more the way in which the NMC presented the case to the Committee. In my judgment, the NMC was wrong

    i) not to open the case (see paragraph 54, above); the absence of an opening of the case deprived the Committee of important information about, in particular,

        a) what the injuries were, and

        b) the significance of the fact that the Second Respondent accepted that the Family Court had found that they were non-accidental;

and prevented the Committee from supervising the decision to offer no evidence;

ii) to suggest that

a) the Committee had power to accept a submission of no case to answer (1) without hearing evidence and (2) at the instigation of the NMC (see paragraph 54, above);

b) the NMC had not been able to get information about the exact conclusion of the Family Court when, in truth, the NMC had made no effort to get it;

c) without the judgment of the Family Court charge 2 could not be proved, particularly since, as the NMC told the Committee, the NMC and the Second Respondent agreed that the Family Court, had found, in effect, that both parents were potential perpetrators of the non-accidental injuries and that both parents failed to protect Baby A, but in any event, there was other evidence from which charge 2 could have been proved, that is,

i) the documents which the NMC's case examiners had considered, and,

ii) other more direct evidence, such as evidence from the various professionals who had examined Baby A, and which the NMC had made no effort to obtain, from which the allegation could be proved;

d) to tell the Committee that the question for the Committee at that stage was whether the NMC could prove the charge; the question, rather, was whether there was evidence which raised a case to answer;

iii) to say that the NMC had 'no medical records in respect of [Baby A] which detail any injuries' when the NMC had made no effort to get any, as this statement suggested, inaccurately, either that no such records existed or that the NMC had tried to, but could not, get them;

iv) to say that there was no medical evidence which 'demonstrates that any injuries suffered by Baby A were non-accidental in nature', but only 'mere references' to non-accidental injuries in the documents which the NMC considered were not admissible, and that the Committee could not test their accuracy, when, given the seriousness of Baby A's injuries, the fact that Baby A was too young to be independently mobile, and the complete absence of any plausible explanation of the injuries, which Baby A had suffered over a period of time, it should have been obvious that the injuries must have been non-accidental;

v) for the reasons I have given above, to suggest to the Committee that there was no written record of the judgment of the Family Court, and that it was disproportionate to 'proceed with the request for further documents', in particular because 'it is far from clear if the NMC's application for further

documents would succeed', when there was no basis for suggesting that an application, if made, was likely to fail, and the NMC had been told it could get a transcript of the oral judgment;

vi) at page 3E-F of the transcript, to quote selectively from what, it was agreed, the Family Court had concluded, and to omit the agreed finding that 'both parents had failed to protect [Baby A]', and to suggest that the issue raised by charge 2 was whether the Second Respondent had 'directly' or 'indirectly' caused non-accidental injuries to Baby A;

vii) to suggest that the NMC had made 'attempts' to obtain evidence which had failed when all the NMC had done was to write the 3 June 2016 letter.

60. It follows that I also accept Mr Bradly's submission that the Committee was not helped by the NMC in five important respects.

i) It did not have an accurate picture of the steps taken by the NMC to get evidence.

ii) It did not know what positive case the NMC could have put forward on the basis of the material which the NMC did have. It is far from clear, I add, that the NMC itself knew.

iii) It did not know what evidence was available to the Case Examiners.

iv) It knew nothing about the extent, timing, and seriousness of Baby A's injuries. Miss Fleck had to accept (rightly) in her oral submissions that 'the nature of the harm was never before the Committee'.

v) It was not helped to understand the nature of the charge.

61. I hope that I do not underestimate the difficulty of giving legal advice to a Committee in the middle of a hearing, when there is little time to reflect on the question which has arisen. Nonetheless, the legal assessor gave the Committee the wrong advice. She was wrong to say that the Committee could, without hearing any evidence (as she acknowledged), and at the instigation of the NMC, accept a submission of no case to answer. She was also wrong to suggest that the Committee's only option was to find that there was no case to answer. The Committee could, for example, have probed the NMC's assertions about its attempts to get evidence, and have asked the NMC to go away and look for more evidence. But the Committee was not given the information which would have enabled it to exercise this option, because of the partial and inaccurate way in which the case was presented to it.

62. For these reasons, I accept Mr Bradly's overall submission that the decision of the NMC to offer no evidence and the decisions of the Committee to endorse that approach, and/or that there was no case to answer, were wrong in law. They were decisions which no reasonable NMC or Committee could have reached. Moreover, in my judgment, the only decision which the NMC could lawfully have made was that it should have offered evidence in this case, and the only decision which the Committee could lawfully have made was that there was a case to answer.

63. I reject Miss Fleck's submission that the decision that there was no case to answer was open to the Committee 'even if findings along the way are not'. She made several submissions about the merits of the case against the Second Respondent, or submissions which might have mitigated any penalty, but which did not, in my judgment, undermine in any way the fact that the Second Respondent had a case to answer. Some of those submissions were not, in any event, securely grounded in the apparent facts. For example, I reject her submissions that the injuries were only suffered after the Second Respondent went back to work and that she was the only person who 'escalated matters'. Some of the injuries were suffered during a period when the Second Respondent was doing agency shifts for an entity other than the Employer, and not, apparently working full-time, and even after she went back to work with the Employer, it seems that she was not working full-time. She was not the only person who 'escalated matters', and from the available material it seems that it was not the Second Respondent's decision that Baby A should be taken to hospital. I also reject her submission that there was no evidence that the Second Respondent knew about Baby A's injuries. First, she knew about Baby A's several bruises, which, of themselves, are a concern, as any nurse would know. Second, there are the reported findings of the Family Court that she and her partner were the potential perpetrators, and that both had failed to protect Baby A. Third, there are the examples of what Mr Bradly described as 'dissimulation' among the factors I numbered in my summary of the facts.

64. I also accept Mr Bradly's submission that the effect of the legislative framework is that, absent special circumstances, decisions about allegations of misconduct are, under rule 6C (2)(a)(ii), for the NMC's independent committees to make, and not for the NMC's officials to make. In this case, the NMC decided, on an erroneous basis, that there was no case to answer, despite the decision of the Case Examiners that there was such a case, despite having material which led ineluctably to the conclusion that there was a case to answer.

65. It is not necessary for me to decide whether the NMC had enough evidence confidently to proceed with the hearing, which is a different question from whether it had evidence which constituted a case to answer. I nonetheless record my unease at the superficial approach which the NMC took to gathering evidence. The NMC recognised that evidence about the proceedings in the Family Court was relevant, but took no proper steps to get that evidence. It simply gave up when it received HMCTS's reply to its inquiry, and then, wrongly, decided that it would be disproportionate to do more. It does not seem to have considered whether it could get relevant and more direct evidence to support the allegation from other sources, such as from the various medical professionals who had dealt with the case. I consider that such an approach does not in any way recognise the public interest in the thorough investigation of allegations of misconduct by registrants, and the need to maintain public confidence by investigating such allegations properly. The NMC has express powers to require evidence, and they have been given to the NMC to enable it to investigate allegations properly.

66. I also therefore consider that the NMC's approach to gathering evidence in this case was flawed. The NMC relied on its own minimal efforts to gather evidence in order to offer no evidence, when the facts clearly demanded an answer from the Second Respondent. I was not impressed by Miss Fleck's submission that the documents she

showed me in the course of her oral argument suggested anything more than minimal effort by the NMC investigators.

67. The NMC, knew, or should have known, from the documents which it had, that there was a range of potential sources of evidence. There was the transcript of the hearing in the Family Court, the transcript of the Family Court's judgment, and there were the medical records considered in the Report (GPs' notes, health visitors' records and the Review, for example). The NMC could have asked for those documents. It could also have asked those professionals for witness statements, if necessary. The NMC took too passive an approach to gathering evidence. As Mr Bradly put it, the investigating team did not consider what other information could be obtained by 'the active use of the powers conferred by article 25 of the 2001 Order'. There is no suggestion in the documents I have seen that anyone ever took stock of what evidence the NMC had in support of charge 2, and what further evidence it might look for to support it. The NMC realised that it should make an effort to get documents about the Family Court proceedings but did nothing to get them apart from writing one letter, and then wrongly gave the impression that (a) it had tried harder than it had done, and had failed and, (b) that it would be disproportionate to do more. It is for the NMC, not for me, to decide what evidence it needs to support and prove charge 2. I consider, nonetheless, in the light of the evident errors in its approach to gathering evidence, that the NMC must think again about whether it should obtain more evidence in this case.

Conclusion

68. I allow the appeal. I heard counsel's submissions about remedy at the hearing. I quash the decision of the NMC to offer no evidence on charge 2, and the decision of the Committee that there was no case to answer on that charge. I remit the case to the NMC with directions (1) to the NMC (a) to reconsider whether or not it should gather further evidence in support of charge 2, (b) if it decides to gather more evidence, to use its best endeavours to gather that evidence; but (c), in any event, then to present evidence to the Committee on charge 2; and (2) to the Committee to rehear particulars of charge 2 when the NMC has complied with the directions (1)(a) - (c). I should make clear that the NMC is free to reformulate charge 2 if it considers, in the light of evidence, that different words would better encapsulate the obvious concerns about the Second Respondent's fitness to practise which are provoked by the facts of this case.