Section 29 Case Meeting

09 February 2022

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

William Munro

Members present
Alan Clamp (in the Chair), Job title, Professional Standards Authority
Dan Scott, Accreditation Officer, Professional Standards Authority
Mark Stobbs, Director of Scrutiny & Quality, Professional Standards Authority

In attendance
Nicola Kohn, Counsel, 39 Essex Street Chambers

Observers
Jane Carey, Director Corporate Services, Professional Standards Authority
Siobhan Carson, Senior Scrutiny Officer, Professional Standards Authority
Caroline Corby, Chair, Professional Standards Authority
Rachael Martin, Scrutiny Team Coordinator, Professional Standards Authority

This meeting was held remotely due to the ongoing pandemic.

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 The Legal Advisor 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 14 February 2022.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 9 December 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:

- Determination of the Panel dated 9 December 2021
- The Authority's Detailed Case Review
- Transcripts of the hearing dated 6-9 December 2021
- Counsel's Note dated 6 February 2022
- Final Hearing Bundle
- Hearing Exhibits Log
- IC Bundle
- ICP Decision
- Outcome email to Registrant
- The HCPC's Sanctions Guidance

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

- The Authority's Section 29 Case Meeting Manual

7.2 The Members and the Legal Advisor were provided with a copy of a response from the HCPC to the Authority's Notification of s.29 Meeting. The Members considered the response having received legal advice and after they reached a conclusion on the sufficiency on the outcome.

8. Background

8.1 This was a substantive hearing before a Panel of the HCPTS. The Registrant, a paramedic, did not attend the hearing and was not represented, and the hearing proceeded in his absence.

8.2 The HCPC received an allegation in January 2019 from the Welsh Ambulance Services NHS Trust (the Trust) concerning the registrant's behaviour at a 999 call-out on 6 January 2019. It was alleged that, arriving at the call to assist another crew of Emergency Medical Technicians (EMTs) that had requested back-up, the Registrant was verbally and physically threatening to a patient. The patient was intoxicated, had been suicidal and uncooperative (hence the call for assistance). In the process of placing the patient in the ambulance, the Registrant was alleged to have held the patient's arms and/or face, threatened to break the patient's "fucking arm", did not use an appropriate technique to transfer the patient from the floor to a wheelchair and did not make any record of the interaction with the patient. Colleagues raised concerns through records made after the call-out.

8.3 The Trust had undertaken an investigation which involved taking statements from eyewitnesses and the Registrant, who had engaged with the process. The investigation concluded in July 2019 with gross misconduct being substantiated. The Registrant was given a final written warning for 2 years with corrective actions.

8.4 The allegations before the panel include those relating to the conduct described above and that the Registrant had not made any clinical records in relation to the call-out. The Panel found all the charges proved, that the Registrant's behaviour amounted to misconduct and that his fitness to practise was impaired on both the personal and public components. Some charges were amended.

8.5 The Panel went on to impose a suspension for 12 months. A review of the suspension will be carried out.

8.6 Prior to the hearing the Registrant had received a caution in 2009 in relation to misconduct occasioned by failure to attend two 999 callouts in 2006, apparently with no explanation to colleagues at the time. It appears that the Panel took into account a diagnosis of PTSD (in remission by the time of the hearing) brought on by two occasions where the Registrant had been working alone and members of the public had brandished knives at him. There is no reference to this previous case in the instant decision or in the hearing papers and transcripts. The case is referred to in the Investigating Committee bundle but only to note that there were limited details available and no indication as to the outcome of the case.

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:

Under-prosecution – Amendment to charges

9.3 The Members noted that, at the hearing, the drafting of Charge 1, alleging that the registrant had used "excessive physical force" had been amended to allege "unnecessary physical force" instead. They considered whether this amounted to undercharging and had materially affected the conclusions reached by the Panel at the sanction stage.

9.4 The Members considered that the amendment was not necessary, and that the case could have been charged either way. They noted that the charges did not refer directly to the vulnerability of the patient and particularly her age in the charges. The Members were satisfied from the decision, however, that the Panel in fact had the full picture of the conduct before it and did not underestimate the seriousness of the misconduct. They were not convinced that the amendments made any material impact on the case or sanction reached.

Under-prosecution - Candour and dishonesty

9.5 The Members considered whether the failure to allege lack of candour or dishonesty in the Registrant's failure to make clinical records demonstrated under-prosecution.

9.6 The Members were not satisfied that there was enough evidence to suggest that a lack of candour or dishonesty should have been charged in terms of the Registrant's failure to make a clinical note following his attendance at the call-out. The Members acknowledged that although it was the Registrant's primary duty to report the incident and to make a clinical record there were other colleagues present who could also report the incident. The Members also accepted that although there was a motive for the Registrant to not make any clinical records, he must have been aware that others present could report the incident.

9.7 The Members concluded that lack of candour could have been an appropriate charge but there was insufficient evidence to suggest that the Registrant's failure to make a clinical record was intentional.

Sanction

9.8 The Members considered the Panel's conclusions at the impairment stage on insight and remediation against its reasoning for imposing a suspension when also addressing insight and remediation. The Members went on to consider whether the difference in the Panel's views at the different stages could constitute a "striking disjuncture".

9.9 The Members agreed with the Panel's assessment that there was very limited evidence of insight. The Registrant had admitted being brusque with the patient and that he could have handled the situation differently. When considering

sanction, the Panel referred to its earlier findings at the impairment stage in terms and stated that, "*it was uncertain whether [the registrant] may be able to resolve or remedy the misconduct".*[2] The Members concluded that it was surprising that the Panel then went on to state that it would be disproportionate to impose a striking off order given their "uncertainty" in terms of remediation. The Members felt that the decision to suspend the Registrant lacked clarity given the Panel's findings in respect of insight and remediation at the sanction stage.

9.10 The Members also considered that it would have been appropriate for the Panel to have also considered aggravating factors such as the Patient's vulnerability and the sheer inappropriate behaviour towards the Patient at this stage.

Application of Sanctions Guidance

9.11 The Members considered whether the Panel gave adequate consideration to the SG and to the factors which indicated when a striking off or suspension may be appropriate. The Panel acknowledged that the Registrant's insight was limited and concluded that the misconduct was remediable but did not make any conclusions about the Registrant's ability and willingness to remedy his misconduct.

9.12 The Members were mindful that the misconduct appeared to have been a one-off incident and that there was no evidence of repetition. While very bad behaviour, the Members felt it was not at the highest end of the scale and agreed with the Panel's assessment that the conduct was not premeditated, nor demonstrative of attitudinal issues.

9.13 The Members felt that the Panel could have said more about its consideration of mitigating and aggravating factors, particularly the aggravating factors such as the Patient's vulnerability and the potential for harm to the patient. The Members considered that the Panel could have said more around the Registrant's failure to complete the patient's clinical records.

9.14 The Members acknowledged that the Panel's reference that it was "uncertain" about whether the Registrant could remediate was likely to be an accurate statement of the position. The Members agreed that it was difficult to be sure given the limited evidence before the Panel. It was hard to show that the Panel's assessment was wrong.

9.15 The Members concluded that the SG had been applied appropriately and that it was probably open to the Panel to impose a suspension with a review and that there was just enough insight demonstrated to justify the outcome.

Conclusion on insufficiency for public protection

9.16 The Members concluded that the conduct in this case did not of itself warrant erasure. While the Members had concerns about the Registrant's insight and the Panel's consideration of this at the sanction stage, they considered that it appropriate to defer to the Panel's view on this. The Members were satisfied that there was no evidence to suggest repetition was likely and that the serious misconduct found proved was addressed by the suspension imposed. The

[2] Page 17 Determination of the Panel dated 9 December 2021

Members concluded that the decision was not one which no reasonable Panel could have made. In all the circumstances, therefore, it 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 HCPC.

21/02/22

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	A Conduct and Competence Panel of the HCPTS
The Registrant	William Munro
The Regulator	Health & Social Care Professions Council
HCPC	Health & Care Professions Council
HCPTS	Health & Care Professions Tribunal Service
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 9 December 2022
The Court	The High Court of Justice of England and Wales
The SG	Regulator's Sanctions Guidance