Section 29 Case Meeting

20 April 2020

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

[redacted]

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Mark Stobbs, Director of Scrutiny and Quality, Professional Standards Authority
Graham Mockler, Assistant director of Scrutiny and Quality (performance), Professional Standards Authority

In attendance
Peter Mant, Counsel, 39 Essex Chambers

Observers
Kisha Punchihewa, Head of Legal (Senior Solicitor), Professional Standards Authority
Rebecca Senior, Solicitor, Professional Standards Authority
Georgina Devoy, Senior 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 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 21 April 2020.

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
- The Authority's Detailed Case Review
- Transcripts of the hearing
- NMC notification letter dated [redacted]
- Letter from [redacted] to the Authority dated [redacted]
- The NMC's Code
- The NMC's Indicative Sanctions Guidance
- The Authority's Section 29 Case Meeting Manual

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

7.2 Representations from the Registrant's representative at the Royal College of Nursing.

8. Background

8.1 The Registrant was employed by the [redacted] NHS Trust ("the Trust") as the [redacted] between [redacted] and [redacted].

8.2 The Registrant had a successful career and an unblemished record before taking up employment at the Trust. She worked in various senior roles for [redacted] (later [redacted]) up to [redacted] when she became [redacted] at [redacted] ([redacted]). She held this role for three years before moving to the Trust. After leaving the Trust she worked for a period of over a year as [redacted] for [redacted]. She also undertook work as a specialist advisor to the [redacted]. No concerns have been raised about her performance in these roles.

8.3 [redacted] NHS Trust ("the Trust") was created on [redacted] to deliver community health services to people in their own homes and at various locations across [redacted]. The services that it ran included: (i) a Community District Nursing Service ("CDNS"); (ii) an Intermediate Bed Based Care Service ("IBBCS"); and (iii) heath care services at [redacted] ("the Prison").

8.4 The Trust has been the subject of various reports and Inquiries which found that it was dysfunctional and had inadequate leadership from the outset. Concerns include poor governance, an inexperienced executive team and lack of effective scrutiny from Non-Executive Directors. The Trust had to meet challenging savings targets that were externally imposed, but the Board also chose to pursue Foundation Trust status which required it to meet stringent financial criteria, and aggressively pursued costs cutting targets

8.5 The charges against the Registrant fell broadly into two categories- management failings and bullying.

8.6 The alleged management failings included:

- Failure to ensure an adequate Quality Impact Assessment ("QIA") process was followed in respect of Cost Improvement Plans ("CIPs") (allegation 1);
- Failure to take adequate action in respect of reported inadequacies and concerns in relation to the CDNS (allegation 2) and IBBCS (allegation 3);
- Attempting to minimise concerns in respect of the CDNS and IBBCS (allegation 4);
- In relation to services provided at the prison, (i) failing to ensure SUI reports were conducted into deaths in custody, (ii) failing to ensure adequate escalation and/or action following concerns raised in PPO reports, (iii) failing to take adequate action in respect of various concerns,

and (iv) failing to ensure that adequate standards of care were maintained (allegation 5);

- Failing to take adequate action in respect of an alleged assault/hostage taking of a member of staff by a patient (allegation 6); and
- Dishonestly amending a records of an interview with the Deputy HR Director ([redacted]) (allegations 7 and 8).

8.7 The bullying allegations involved bullying of two colleagues – Colleagues A and B – over a prolonged period. Both were relatively senior and were already in post when the Registrant was appointed and had worked for the predecessor Trust.

8.8 The case against the Registrant was heard alongside cases against the Head of Health Care and two Primary Care Managers from the Prison (Registrants B, C and D). The charges against those registrants concerned failure to adequately escalate or take adequate action in respect of reported inadequacies; failure to ensure that investigations and SUI reports were undertaken; and discouraging staff from reporting adverse incidents. The Panel found no case to answer in respect of these cases and accepted that there was evidence that they were reporting and escalating concerns.

8.9 The hearing took place over a total of [redacted] (although a significant number of those days were non-sitting days). At the fact-finding stage, the Panel heard evidence from [redacted] witnesses on behalf of the NMC and five character witnesses on behalf of the Registrant, as well as hearing from the Registrant in person. The Registrant denied the allegations, emphasising the size of her role, the pressures that she was under and lack of support from the Board. The determination on the facts was handed down on [redacted]. The panel found the majority of the allegations proved.

8.10 Stage 2 of the proceedings commenced on [redacted]. The Panel heard further evidence from the Registrant and one additional character witness. The Registrant also submitted a reflective piece which included some expressions of regret and identified some areas where her practice had changed (such as getting people to check her important emails). She stated that she accepted Colleagues A and B felt bullied and apologised for how she made them feel, but she continued to maintain that she had not acted as alleged and much of her reflection and oral evidence focused on the pressures she felt she was under and on the role of others, including the Chief Executive. She stated that she could not “square” the charges against her with the person that she knew she was. The decision on misconduct and impairment was handed down on [redacted]. The decision on sanction (and interim order) was handed down on [redacted].

8.11 The Panel found that all but one of the charges individually and cumulatively amounted to misconduct, noting that the management failings: (i) represented a prolonged failure to take adequate action in respect of significant concerns in three separate areas of the Trust; (ii) occurred over an extended period; and (iii) compromised the care of patients.

8.12 It noted that the bullying occurred over a lengthy period and involved four different members of staff all of whom were junior to the Registrant; (ii) the

Registrant's actions impacted on the mental health and well-being of the staff; and (iii) the "severe impact" of the bullying was likely to have impacted on patient care.

8.13 In determining that the Registrant's fitness to practise was impaired, it stated that the Registrant's management failings had compromised levels of service which exposed patients to unwarranted risk of harm; and her management failings and bullying conduct also brought the profession into disrepute and breached fundamental tenets of the profession.

8.14 The Panel accepted the evidence from character witnesses who worked with the Registrant before or after her tenure at the Trust that they found her to be an "effective, supportive and respected senior leader". To this extent, the Panel accepted that the charges were "out of character" in an otherwise long, unblemished and successful career. However, it noted that the charges were serious and spanned her entire three-year tenure at the Trust.

8.15 The Panel accepted that: (i) the Trust was already in a difficult situation when the Registrant joined in [redacted] and that these difficulties persisted after she left; and (ii) there were others with responsibility for governance. However, it found "in relation to this aspect" that the Registrant had still not "fully" accepted personal responsibility and accountability for her failings.

8.16 It stated that the reflective piece demonstrated "limited" insight. Whilst the Registrant appeared to accept some responsibility this was followed with criticism and blame for others, seeking to minimise that responsibility. It was concerned that, whilst the Registrant had recognised the scale of her role and financial drive as "trigger points", she had not linked it to her behaviour at the time. It noted that little, if any, consideration was given to the effect of her behaviour on patients or staff.

8.17 In relation to remediation, it noted that work the Registrant had undertaken while she had been under interim suspension involved using some relevant skills, but that she had not undertaken any training relevant to her previous role in the NHS.

8.18 Taking all these matters into account, the Panel was not satisfied that, if she found herself in a similarly "undoable job" and pressured environment, away from her support network, that she would not revert to conducting herself in the way she had done at the Trust. It stated that the Registrant had not demonstrated "full enough" understanding of her failings to reassure the Panel that there was no risk of repetition. It therefore found that the Registrant's fitness to practise was impaired on public protection grounds.

8.19 It also found that public confidence would be "wholly undermined" if a finding of impairment was not made.

8.20 At the sanction stage, the Panel identified the following aggravating and mitigating factors

8.21 It rejected taking no action, imposing a caution or imposing conditions, before going on to consider suspension. It stated that the nature of the misconduct could not be addressed through retraining and conditions of practice.

8.22 It cited relevant parts of the Sanctions Guidance in respect of suspension which stated that suspension may be appropriate where the misconduct is not "fundamentally incompatible" with continued registration and identified factors which indicate that this is more likely to be the case, namely:

- 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

8.23 The Panel noted that, although there had been a clear breach of fundamental tenets of the profession, there were mitigating circumstances. It considered that the failings had to be looked at in the context of the Registrant's overall career and "the circumstances and nature of [her] role at [the Trust]". It noted that all character witnesses spoke of the Registrant's professionalism in exceptional terms and cited the Interim Chief Officer of [redacted] who stated that "I believe the profession would suffer a grave loss should [the Registrant's] name be removed from the register".

8.24 The Panel considered that the bullying charges were of an attitudinal nature, but held that the character evidence it had heard suggested this was out of character. It referred to evidence that she had mentored and developed the careers of a number of the people who gave character evidence, and stated that it was satisfied that any attitudinal problem exhibited at the Trust was not deep-seated or irredeemable.

8.25 While it had found limited insight at the impairment stage, it noted that the Registrant had just two weeks to reflect on its findings of fact before giving evidence. It stated that this was a short time to reflect and re-evaluate in the overall context of the case. It saw "no reason why, at this stage, if you were given further opportunity to reflect you would not be able to develop your insight further".

8.26 The Panel stated that, although it had determined that there was a risk of repetition "it did not consider that this risk was so significant as to warrant a striking-off order". It stated that it was not in the public interest to permanently remove such an experienced and respected nurse from practice. On this basis it found that striking-off would be disproportionate. It did not consider the guidance on striking-off or how this might be relevant to the case.

8.27 The Panel imposed a 12 month suspension with review.

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:

Was the sanction of a 12 month suspension order, with review, sufficient to satisfy public protection and public confidence in the profession?

9.3 Prior to their consideration of this point, the Members agreed that there were no areas of concerns with the Panel's finding of fact as well as the misconduct and impairment findings.

9.4 The Members agreed that the main issue in this case was the adequacy of the sanction imposed.

9.5 The Members considered a number of different factors when considering whether the sanction was sufficient, firstly;

9.6 The circumstances at the Trust:

- The Members were concerned that the Panel's reasons at the sanction stage did not address in any detail: (i) what it was about the prevailing circumstances at the Trust that mitigated the gravity of the misconduct; or (ii) the extent to which the Registrant contributed to these circumstances. The Members considered that it made it difficult to understand exactly how the Panel perceived these matters.

- However, the Members agreed that there was ample evidence before the Panel to justify the finding that the circumstances at the Trust were very challenging. The Members noted that the Trust was under significant financial pressure; the Registrant's role was very extensive (it was split after she left); and difficulties were already present when the Registrant arrived and persisted after she left.

- The Members considered that the Panel could be criticised for not analysing these issues more closely, explaining in more detail the weight that was attached to this mitigating factor, and the extent to which it considered that the Registrant played a part in creating the challenging environment by failing to escalate concerns and contributing to a culture of bullying. As a member of the Board she had a duty to seek to address these concerns which she failed to do over three years. However, the Members agreed that the Panel were not necessarily wrong to rely on context as a significant mitigating factor, as in the Bawa-Garba case.

9.7 Insight;

- The Members noted the Panel's statement that it saw "no reason why, at this stage, if you were given further opportunity to reflect you would not be able to develop your insight further." Whilst the Members considered this a generous approach, especially as the Registrant had ample time from when these allegations arose to develop insight, they noted that at the impairment stage of proceedings, the Panel did not find that there was no insight, rather that her insight was limited. The Members further noted the Registrant's records before and after her tenure at the Trust, as well the oral evidence she gave to the Panel and agreed that this was another reason to believe that further insight was possible.

- The Members concluded that, whilst another Panel could have come to a different conclusion, the Panel's decision to afford the Registrant further time to develop insight, was not unreasonable.

9.8 The NMC's Sanctions Guidance;

- The Members noted that the Panel cited passages of the sanctions guidance on suspension but did not cite the passages on erasure.
- Of the passages that were cited, (this was not an isolated incident, there was arguable some evidence of a deep-seated attitudinal failing and limited insight) the Members considered that these pointed to the more serious sanction of strike off and that the Panel had failed to provide adequate reasons as to why strike off was not imposed.
- Further, the Members were concerned that the Panel had failed to address specific parts of the Sanctions Guidance that set out three key considerations for considering striking off, namely:
  - 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?

9.9 Whilst the Members noted that these were key considerations, they agreed that they did not point obviously to strike-off being the appropriate sanction in this case, and that this was guidance.

9.9 Weight given to aggravating and mitigating factors;

- The Members noted that the NMC had raised concerns about the weight attached to aggravating and mitigating factors. However, the Members noted that weight is very much a matter of judgment for the Panel. Whilst the Panel did not expressly state what weight it gave to different factors, it is clear from its reasoning as a whole that it placed little emphasis on the Registrant's voluntary work and that her long distinguished career and potential to contribute positively in the future were the primary reasons for the decision that it reached.
- The Members agreed that the Panel had failed to grapple explicitly with the aggravating and mitigating factors, but concluded that there were mitigating factors, from the decision as a whole, it was possible to understand why the Panel had reached the decision it had.

10. Can public confidence be maintained without striking-off?

10.1 The Members noted the issue of public confidence was not addressed at all in the Panel's reasoning on suspension or erasure. The only reference to it at sanction stage was when the Panel stated that the order would mark the importance of maintaining public confidence in the profession and would send to the public and the profession a clear message about the standard of

behaviour required of a registered nurse. The failure to consider whether maintenance of public confidence required erasure arguably was a material flaw. However, taking in all the factors of the case and particularly the context of the case, the Members agreed that whilst serious, the Registrant's actions were not so serious on public confidence grounds that strike off was the only reasonable sanction available to the Panel. The Members noted that a 12 month suspension with review is the second most serious sanction available to a Panel.

Conclusion on insufficiency for public protection

10.2 The Members considered that this was a serious case and that erasure was open to the Panel. However, it also considered that it was open to the Panel to take account of the context, the registrant's career and that there was some insight. The 12 month suspension would ensure that the public protection elements were addressed and the review that was ordered would be able to consider whether progress had been made. The mitigating circumstances were such that it could not be said that erasure was manadated. Therefore, despite the flaws in the decision, the Members considered that the 12 month suspension order with a review was not insufficient to protect the public.

11. Referral to court

11.1 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.

12. Learning points

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

28 April 2020

…… **……**

Alan Clamp (Chair) **Dated**

13. Annex A – Definitions

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

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	A Fitness to Practise Committee of the NMC
The Registrant	[redacted]
The Regulator	Nursing and Midwifery Council
Regulator's abbreviation	NMC
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 concluding on [redacted]
The Court	The High Court of Justice of England and Wales
The Code	Regulator's Code of Practise
The SG	Regulator's Sanctions Guidance